MAY-JUNE, 1959

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Group Psychotherapy at the ARC

Let's Be Objective When We Teach About Alcohol

Putting Balance Into Your Life

My Dear Drunks

Self-Discovery, Faith, Love

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N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultatons with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a phychologist, social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
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INVENTORY

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RALEIGH, N. C.

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News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

NEW YORK: Miss Roberta Lytle, Psychiatric Social Work Consultant with the ARP, was the chief discussant of a paper delivered by Dr. Ruth Fox at the annual conference of the American Society of Group Psychotherapy and Psychodrama, held in New York, April 24 and 25.

UTAH: North Carolinians in attendance of the National Council on Alcoholism's annual meeting and institutes held in Salt Lake City, March 18-20, were William J. McCord, Educational Director of the Educational Division of the ABC Board in Asheville, and William Hales, Associate Director of the Council of Alcoholism in Charlotte.

STOCKHOLM: Although a year early, plans are already in the making for the 26th International Congress Against Alcoholism, which will be held from July 31 through August 5, 1960. The Congress will be presented under the patronage of His Majesty King Gustaf VI Adolf. Professor Leonard Goldberg and other leading Swedish experts on alcohol and alcoholism are acting as advisors to the Congress.

NORTH CAROLINA: The 1959 Summer School of Alcohol Studies on Facts About Alcohol and Alcoholism will be held June 9 through June 19 at East Carolina College, Greenville, and North Carolina College, Durham. Dr. Norbert Kelly, Executive Director, and George H. Adams, Educational Director, of the ARP will lead the two sessions, each of which offers to the student 3 quarter hours college credit. The courses are open to any teacher or prospective teacher in North Carolina. Further details of the Summer School can be found on page 9 of this magazine.

RALEIGH: The Scholarship Committee of the ARP has chosen twenty-one North Carolinians as recipients of full scholarships to Yale Summer School of Alcohol Studies June 28-July 23. For several years now the ARP has selected outstanding individuals to attend the Summer School, considered to be the foremost of its kind in the country. North Carolina has always been at the top of the list of states sending the most number of students to Yale. This year, the following professional workers will be sent to the Summer School from North Carolina: Gene Bass, Goldsboro; James E. Brown, Lumberton; Robert H. Bruhn, Asheville; Grace Daniel, Salisbury; Margaret Davis, Wilmington; Alphonso L. Finch, Littleton; John F. Flynn, Ruffin; Howard S. Gailey, Greensboro; Cranor F. Graves, Leaksville; Cecil E. Long, New Bern; Mary Metler, Charlotte; Valerie Nicholson, Southern Pines; James H. Pernell, Winston-Salem; Marion Person, Fayetteville; Charles B. Robson, Raleigh; Frances Setzer, Concord; Frederick E. Still, Red Springs; Mason Thomas, Gastonia; Frances Walker, Wilmington; Anne Wall, Reidsville; and Jerome Wilson, High Point.

WINSTON-SALEM: The 12th North Carolina Convention of Alcoholics Anonymous will be held May 22-24 at the Hotel Robert E. Lee. AA's from throughout the state will be on hand for this annual gathering.

CANADA: Five Canadian provinces now have flourishing provincially-supported programs on alcoholism. They are: Ontario, Manitoba, Saskaetchewan, Alberta and British Columbia. Each program is a non-profit foundation, established to provide treatment, educational and research services in the field of alcoholism.

MASSACHUSETTS: On April 22, the Worcester Committee on Alcoholism presented its second annual conference on alcoholism, featuring talks on "Youth and Alcohol", "The Alcoholic Woman," "Medical Aspects of Alcoholism", "The Role of Alcoholics Anonymous in Rehabilitation" and "Alcoholism as Seen in Industry." Professional workshops were held for those working professionally with alcoholic patients at which Miss Roberta Lytle of the ARP directed a session of psychodrama.

WILMINGTON: A big success was the 1959 Nurses' Institute on Alcoholism, sponsored by the ARP, the three state nurses' associations and the New Hanover County Association for Mental Health, held Friday, April 10 at Wilmington, N. C. Over 50 public health, hospital, private, and industrial nurses heard Dr. John Ewing, psychiatrist from N. C. Memorial Hospital, Chapel Hill, and Dr. Thomas Jones, private practitioner from Durham, speak on the psychiatric and medical management of the alcoholic patient. Miss Roberta Lytle conducted a psychodrama session using the nurses as participants during the afternoon session of the Institute. This is the fourth year that the ARP has sponsored a Nurses' Institute.

NEW HAMPSHIRE: The fifth annual North Conway Institute will be held June 15-19 at Stonehurst Manor, North Conway, N. H. This year's theme will be "Pastoral Care of Alcoholics and Their Families". The North Conway Foundation is primarily a religious-oriented fellowship, composed of representatives of the Protestant, Catholic and Jewish faiths. Among the speakers for this year's Institute will be Dr. Ebbe Hoff, of Richmond, Va., Raymond G. McCarthy of Yale University, the Rev. Yvelin Gardner of the NCA, and John Park Lee, Director of Welfare Agencies, Presbyterian Church, USA. Applications for admission may be had by writing North Conway Foundation, North Conway, New Hampshire.

GREENSBORO: Highly successful was the second annual Greensboro Council on Alcoholism's Alcohol Education Week. Beginning Monday, May 4 with a workshop on the prison alcoholic, the four-day activities included a Ministers Institute on Tuesday, May 5, and a Caseworkers Institute on Wednesday, May 6. Mr. Roberts J. Wright of Valhalla, New York, Warden of the Westchester County Penitentiary and President of the American Correctional Association and Mr. Raymond McCarthy, Associate Director of the Yale School of Alcohol Studies, were among the speakers during the week. Also quite active in presenting the Alcohol Education Week were Dr. Norbert Kelly, George Adams, and Miss Roberta Lytle, all of the ARP staff, who acted as consultants and speakers for the program.

Wants Material

We have recently opened our doors to admit patients, and are attempting to enlarge and complete our reference library which is being used by both the medical staff and the nursing staff. We would be most grateful to be placed on your mailing list to receive INVENTORY and any other related brochures which may be of interest and assistance to us.

Sister M. Mercita, O.S.F.
Director, Nursing Service
Trinity Memorial Hospital
Cudahy, Wisconsin

Wants Services

I am a health educator in Alamance County. I receive your bi-monthly journal which is most helpful. I have checked on the back of the journal the list of educational materials available and I am sure I will take advantage of the service.

L. V. McMahan, Health Educator
Alamance County Health Dept.
Burlington, N. C.

Likes Magazine

I have just completed a week of area school of Presbyterian Churches in Wilson and while there I got a copy of INVENTORY. It is so interesting I would like very much to be on your mailing list. I'm sure it will be a great help to me because I have had a drinking problem.

Anonymous
Farmville, N. C.

N. C. Leads in Literature

While attending an Al-Anon Intergroup meeting, we discussed helpful literature for the family and friends of the alcoholic. Of all the literature available it was discovered that most of it was from the state of North Carolina. My husband went into AA and I into Al-Anon in Winston-Salem two years ago and from the very beginning we had the very best literature made available for us. We would now like to receive INVENTORY and any other literature you could send us for our group here. Anything you can send us regarding alcoholism will be appreciated.

Mrs. J. W. B.
West Memphis, Arkansas

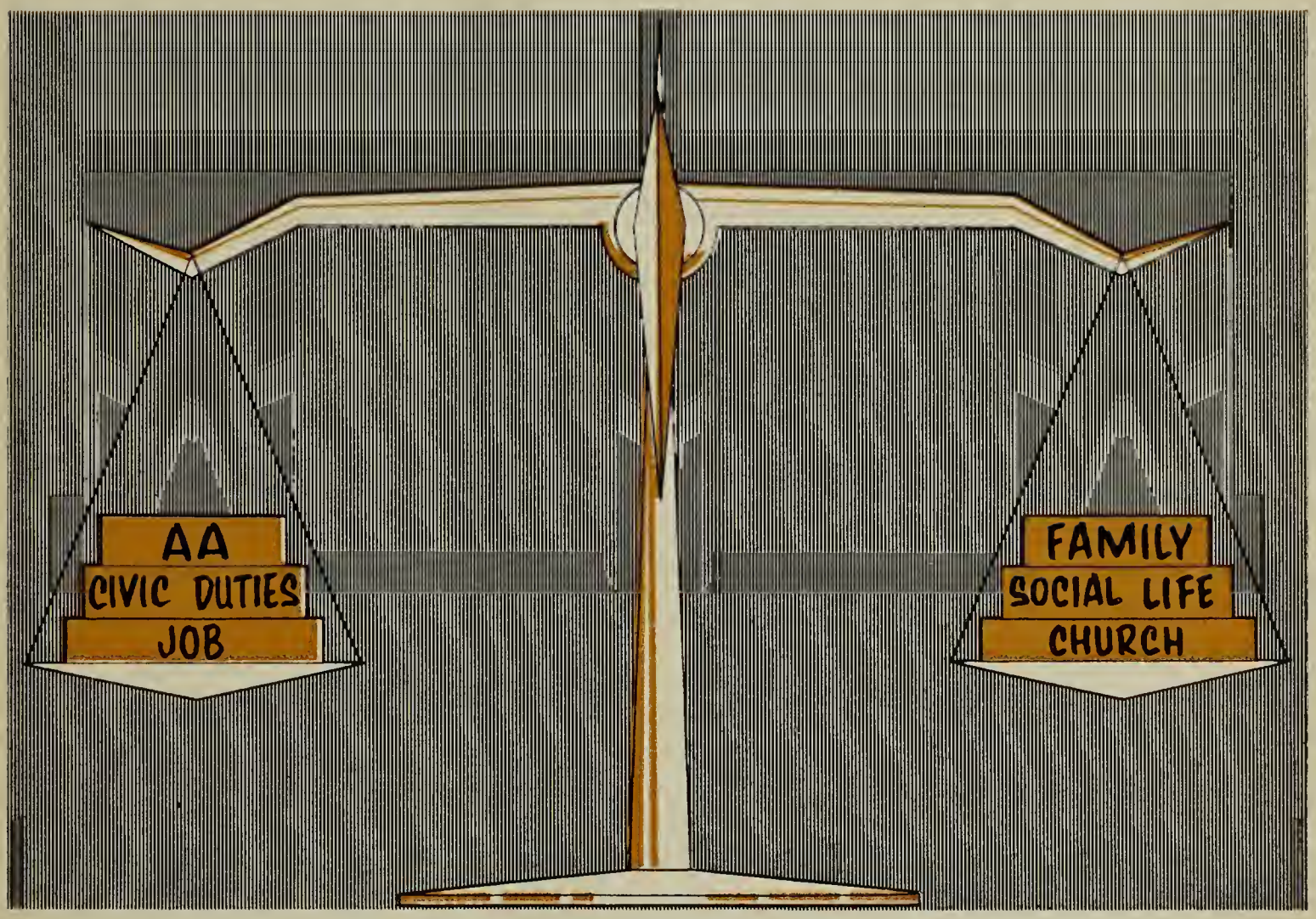
Assembling A Library

I am assembling a small library on the subject, alcoholism, with a view to being able to offer advice at a later date when I am engaged in parish work in my home state of Kentucky. A course on alcoholism is taught here at the seminary by a lawyer from the local AA branch. I would appreciate a copy of the Butner Brochure and Cornerstones if they are still available.

William G. Poole
Saint Paul Seminary
Saint Paul, Minn.

VOL. IX, NO. 1 INVENTORY MAY-JUNE, 1959

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM



Putting Balance Into Your Life

by

Dick C.
Editor, Chit-Chat

I'VE been doing a lot of thinking the past six to eight months. Sometimes we in AA are prone to suggest to others the need of "putting balance into one's life" and not taking the advice ourselves. I guess that is what has happened to me during these past few years. When I sobered up in St. Paul, Minnesota, I heeded the advice of the older members of the group, and "put AA first in my life" and I have never forgotten my last drunk.

Time after time, I have guided my actions on the basis that sobriety is the most important thing in my life, *without exception.* I might believe that my job, or my homelife, or one of many other things could come first. But when I stop and realize, that if I did not get sober and stay sober, chances are I wouldn't have a job, a family, sanity, or even life. And so over these past years I have been convinced that everything in

life depends upon my sobriety and if I put other things first I would only be hurting my chances of continued sobriety. But every alcoholic is a perfectionist, and we have a way of carrying things *just a little bit too far.*

In the beginning I had no outside activities except AA. My charming bride Catherine supported me in countless ways, not only opening her heart, but also her home to the men and women whom I've tried to help over these years. God blessed us with four lovely children. My family was willing to "forget yesterday" and give me another chance.

In 1952 we moved to Pennsylvania. I became active in our local Group and eventually started another group. I continued my personal activities in institutional work, both with the prisons and hospitals. My home became "grand central station".

Joined Many Clubs

Along about 1954 I realized I was becoming somewhat insular, and when I was offered a chance to become a Director of our local United Fund, I accepted with pleasure. Subsequently, I added further responsibilities with the American Red Cross, Berks County Heart Association, Catholic Charities, The Berks County Committee on Alcoholism, the Berks County Manufacturers' Association, and last but not least the chairmanship of our local Sewer Authority. In addition to these "outside activities" I still had a job to accomplish in operating our Robesonia Plant, to offer a little love and companionship to my children, and to be with my wife occasionally. By mid 1958 this "snowball of activities" had grown to such proportions that I suddenly realized that I wasn't doing justice to my job, to my family, or to the many activities that I was engaged in.

And this is the point when AA gave me the answer. A long time ago I learned that I can't do this job alone. God has been on my side, and one of his tools has been my sponsor. I'm just as guilty of rationalization as the next guy. Long length of sobriety doesn't guarantee that this human trait is eliminated. And so I tried to justify, to myself, my many activities . . . only to realize that in sober reflection something was wrong. It took me a few months to "take action". Finally I wrote Lynn, my sponsor, laid my problem in his lap, and asked his advice. Subsequently I received a letter which I would like to share with you. It is self-explanatory. It is to the point. Perhaps his remarks will help others who might have gotten themselves into the same "rat race". Here 'tis:

Letters From His Sponsor

"I just got back this morning, and I found your letter waiting for me. Of course it is very difficult for me to answer. I think I have indicated at times that you have been over-reaching, Dick. You always assured me that it was not affecting the mill in any way. I think a calm reflection will convince you that you cannot have a variety of interests, as indicated in your letter, and still concentrate on business to the fullest extent of your ability. I would suggest that you resign from about everything, and confine yourself as much as possible to local AA interests, even if it required resignation from the United Fund, Heart Association, and Berks County Committee on Alcoholism. I would give some thought about "Chit Chat". Maybe you can rotate the work involved with others.

"I do think, Dick, that you have reached the point where you have to readjust to a new course, particularly in AA. One thing that is important. Much as you think otherwise, you

have neglected your family a great deal. Your children are at an age where if you do not spend time with them now, I can tell you frankly, you'll never have the opportunity again. You'll find they've all grown up. With the recollection that you did neglect them many, many times, you should be with your children enjoying picnics and taking them swimming, fishing, skating, and all the things that normally a father does with his children. It will leave you with better memories than any other association that I know of.

A Sense of Importance

"One thing that I wish you would take a very serious and honest look at is the fact that you may be hesitating in resigning from all these things because you like the titles that are associated with them and the feeling of importance that goes with them. That may be on a very subconscious level; nevertheless, it's there. I know that it took me some time to get to the point where I was content in AA to sit back and review things objectively. I know it is easy for me to talk, and yet I can look back with a lot of regret to the time I did the same thing as you are doing at the present time. Certainly I felt it later on.

"You will always have to watch the same thing in life that I have to watch. We are inclined to go overboard. We're the type of individuals who go out after deer with a shot gun. When you do that, you're certainly wasting a lot of time. If you will only realize, Dick, that at this state of the game, you should concentrate on 1 or 2 things in life. I think your AA associations are necessary, but I would confine them to the local area. Do not accept outside invitations that I know you get. The inclination is to go out and spread your name and fame around. Certainly I deceived myself that way for a long period of time, until I found there were perhaps 100 others who could do the same work and perhaps even better than I could. Then I started to slow down. Now, I go out, not more than 2 or 3 times a year. This aimless scattering of your energies is one of the most frustrating and tiring things that I know of. If you would concentrate your efforts on your work, your family, and AA, you'd have time to yourself to do things, and still help others. It is going to take a big effort on your part, Dick, because I know of your tremendous drive. You will find that all this activity is taking a lot more out of you than you realize. I was imbued with the idea that I could go endless hours, but I'm paying for it at the present time. I think you will find you may have to pay for the same mistake.

Only Sobriety Is Vital

"I think you will find that if you will reorganize your activities, you will be a little lost for a few weeks. But after the new way of life takes over, you'll be much more at peace and ease, and certainly much more efficient both at home, at the office, and in your AA activities. It is going to take a great deal of courage. Watch out for the inclination to chisel on yourself by kidding yourself that it is vital to keep this or that. *Nothing is vital except sobriety.* Keep in mind that all during the years that you and I were drinking, plenty of people were still getting along. They'll continue to get along all right after you and I are gone. While we can do some good for some people, no man can or should kid himself that he is indispensable. After all, your loyalties and deep interests should lie with those you have the greatest responsibilities to and for. That would be your work, your family, and of course, AA. I also know that when I

give advice. I shouldn't expect that it will be taken".

Now I'm still an alcoholic, and sometimes I don't like to read what I know is the truth. And that is the way I felt about Lynn's letter. So what did I do . . . I re-discussed the situation with my good friend, Father Huesman. And he promptly sits on me, as follows:

Letter From Father Huesman

"I have read at least three times, carefully, the letter addressed to you by Lynn, who is your AA sponsor. The lad certainly packs a wallop and in an informal way, yet in a very incisive manner he clearly points out for you, your future mode of action. I applaud Lynn's approach, and, in fairness to his presentation, I would like to say I think he has rightly reasoned your position for you. It takes singleness of purpose to reach an objective—and in keeping with this type of thinking, I honestly believe that you should curtail some of your activities . . . One of the points, Dick, that I have underscored in times past with yourself, is an unintentional neglect of your family. I have a little phrase that it is far better to spend "time" than "money" on your children! And this is not from a selfish viewpoint, wherein in the years that lie ahead, you may look back and feel that you have met your responsibility as a father intelligently and conscientiously, but rather from the other viewpoint that you want to give your children a happy and beautiful memory of a mother and father who shared their time and know-how with them, through boyhood and girlhood; through the adolescent years—and they are most difficult today—into the area of manhood and womanhood.

"One of the factors that has commanded my admiration in watching our friendship grow is the enthusiasm—at times misguided—which you display for community and welfare projects. I say that I have been edified, and at times, even inspired. In this regard, however, you have given evidence of impulsiveness and impetuousity that would shock even the best of statesmen and diplomats. My definition of enthusiasm goes back many years. Enthusiasm is the outward expression of an inward conviction! When a man is entirely convinced interiorly; when a man allows his head and heart to co-operate jointly, he will reveal that with an enthusiasm that borders on dedication! In the hierachy of values in the life of an individual, there is a need for introspection, a looking within and in so doing, recollecting what is not only of primary importance but at the same time also acceptable and in keeping with God's holy will.

Balance Activities

"The sentence that was typed by C. which reads thusly, *'If you will concentrate your efforts on your work, your family, and AA, you will have time to yourself to do things, and still help others.'* The guy has something here! As he said, it is going to take a great deal of courage. How true his words that 'nothing is vital'. The one thing that you want to do well is to be a loving husband, a good father, an efficient businessman and a grateful member of AA. And as Lynn again said, 'Your loyalties and deep interest should lie with those you have the greatest responsibilities to and for.' Over the brief span of our growing friendship, I have tried to indicate how you can polish off the rough surface and use your keen intellect constructively for the greater honor and glory of God and the salvation of the little souls which He has confided to Catherine and yourself. Frankly, I have great confidence in both Catherine

and you, and I think it requires great strength of character as outlined by your preceptor.

During this past month I have tried to make the initial change. It has been difficult. I've resigned from much of my local activities, put more effort into my job at the mill, and surprisingly enough things seem to be working out OK. I still feel that I owe a definite obligation to AA, for my continued sobriety. Perhaps I need AA just a little bit more than somebody else, but I also realize that it is necessary for me to consider the welfare of my family, the proper relationship of my job, and the love of my wife. I haven't found the answers yet . . . but I do know from past AA experience, that if I keep trying . . . *and do something about it, God will give me the answer.*

LET'S BE OBJECTIVE WHEN WE TEACH ABOUT ALCOHOL

by

Raymond G. McCarthy

Associate Professor, Yale University
Center of Alcohol Studies

It is the teacher's responsibility to rid herself of all bias and misinformation

DURING the last decade considerable attention has been devoted to the social problem of alcoholism. Five Canadian provinces as well as more than two-thirds of the states of U. S. A. have passed legislation creating some kind of agency to deal directly with the problem through treatment services or through education. As public awareness of alcoholism as a health issue has increased, attention has been directed toward prevention. In particular, attention has been focussed upon the role of the school.

Alcoholism is a social problem and social problems are always complex. Whether you are dealing with delinquency, race prejudice, crime or divorce, there is always a body of facts, a body of data. There is in addition, a body of attitudes. The attitudes are culturally determined and interpretation of the data is colored by feelings. Where attitudes dominate a situation, changes do not ordinarily come about in response to logic.

There is a considerable body of information available about alcohol and its effects upon the individual and upon society. In what follows we are particularly concerned with the nature and extent of the attitude about drinking customs in our societies and the educator's relation to these attitudes. Unless we can analyze and develop an approach to attitudes about drinking we are not likely to make very much progress in dealing purely with information.

Most of us derive our information about drinking initially from family, from neighborhood associations and from the church. Because of the controversy over prohibition in the U. S. A. and Canada, there have developed barriers to understanding between those who look upon alcohol as a threat to individual and social existence, and those who see in the controlled use of alcohol a resource making for an increase in the satisfaction to be derived from social relations. It is estimated that approximately two-thirds of the adult population in the States and also in Canada use alcoholic beverages at some time during the year. One-third of our people do not drink at all, either because of religious conviction, for reasons of health or general indifference.

Organized Viewpoints

Those who oppose the manufacture and sale of alcoholic beverages are organized and are in a position to publicize their opinions. School legislation requiring instruction about alcohol was enacted years ago in many areas by those who were sympathetic toward total abstinence. I think it is possible to demonstrate that there was much wider acceptance of the principle of total abstinence fifty years ago than exists in our society today. Changes have occurred in drinking customs—changes which involve more widespread acceptance of the custom by women, and by young people. Recent studies in high schools in New York, Wisconsin and Kansas reveal that more than half of the young people participating in the surveys used alcoholic drinks, and a substantial number do so with parental permission.

That there are excesses associated with the use of alcoholic beverages by many drinkers is quite obvious. That these excesses inevitably follow the use of alcoholic beverages has not been established. The development in the classroom of an objective consideration of alcohol use and abuse in our society is handicapped by misinformation and folklore handed down from one generation to another.

What is to be the school's position **regarding the use of alcoholic beverages when she teaches the facts about alcohol.**

now that increased pressure is being brought to bear upon administrators and teachers to assure a more active role than they have demonstrated in the past? It seems to me that we must acknowledge that we live in a society in which cultural attitudes toward the use of alcoholic beverages are strong. We must recognize also that to follow the traditional teaching approach of emphasizing only the threat of physiological harm from drinking is likely to be ineffective inasmuch as this threat has been rejected by the majority of drinkers. To condemn or to sanction drinking practices is in my opinion outside the responsibility of the public school. I believe that we must accept the duty of dealing with this controversial issue in the same manner that we deal with other difficult issues. We must adopt an objective approach which has for its goal to interpret to young people the society in which they are going to function and in which alcohol use is widely accepted. I do not consider this a defense of drinking or of not drinking. I believe it constitutes a defense of objectivity, of intellectual honesty in the classroom.

Traditional Methods Questioned

Much might be said about the effectiveness or lack of effectiveness of traditional teaching about alcohol. I would say about 90 per cent of the teaching about alcohol in the schools in the past emphasized total abstinence. Yet 68 per cent of the adult population of the country today use alcoholic beverages. One study showed that the highest incidence of use of alcoholic beverages was in the age 20-29 years. This is not alcoholism—this is use. This is the age range most recently exposed to the influence of the school.

By educational classification those with high school experience or better showed a higher incidence of use. I leave to you the judgment of the effectiveness of traditional teaching about alcohol. Yet we cannot judge the effectiveness of the school without considering the community, the family, the changing culture in which we live. The effects of the primary group in establishing certain attitudes is of tremendous significance. I suspect that the school during the last twenty-five years has been moving away from the primary groups, has been growing apart from them, so that there is not only a lag in some of our teaching approaches but there is a kind of blocking between the school and the community.

The Old Approach

The traditional teaching approach has been physiologically centered. I think that we might also say it was based on a psychology of fear, of threat. It was negativistic. "If you drink, you'll become insane. If you drink, you'll get liver cirrhosis; if you drink, you will deteriorate socially." The fact that these dramatic changes were not apparent among most drinkers, seemed to reflect on the validity of the statements. It produced some confusion in the minds of the students. They may have lost some respect for the school. It certainly did not give the young person a positive approach to the question.

The emphasis in the biology and physiology classes in the past has made for a restricted interpretation of the personal and social implications of drinking. I have no objection to the material in biology texts. Much of it is excellent. However, too often it remains at the physiological level and never moves into the social level. Moreover, so long as administrators kept it at that level, they could in a sense avoid the controversial element, the political element, questions of religious differences and attitudes.

Much of our teaching has been developed around adult aims and goals. These are worthy, admirable, highly desired. Neverthless there is some question how effective they have been with young people.

The emphasis on teaching total abstinence as the only alternative has been in conflict with what young people saw among adults—in their own families and among other families. The implication that drinking is always disreputable was in conflict with what they observed among people whom they considered reputable. Adults disregard the physiological threats which the school taught as established facts. Even the child who could accept the teaching was left with a feeling of uncertainty about his own family, about his friends.

Not all churches have insisted on total abstinence. How can you set up a single approach when you have wide group difference within your classroom? Not all teachers accept the principle of total abstinence. And there are wide divergences among social groups concerning drinking practices and total abstinence.

A most serious weakness in traditional teaching was that it was not based on student needs. I think good teaching usually suggests beginning where the group is and moving on from there. Adolescent needs are tremendous, the need to be accepted, to be independent, to be an adult. Accompanying these strivings for independence and adulthood exist strivings to remain close to the family, to be dependent; uncertainties about self, about physical and psychological changes, hormonal changes. For many adolescents the potential use of alcohol is a question of not being different, of being accepted—of being daring and adult.

What can we teach? The concept of alcohol as an anesthetic might well be introduced—that it is not a stimulant, that it is not a dehydrant at low concentrations, that the concentration in the body even in a deeply intoxicated man, is less than a fraction of one per cent. It should be emphasized that many of the theories about coagulation, about deterioration of the fatty sheath around the nerves need to be questioned. Certainly there are bodily disturbances associated with uncontrolled drinking. Whether they result from vitamin deficiency or some other cause is secondary to establishing the facts. I don't consider that this constitutes a defense of alcohol or its use. We have a responsibility to support a defense of science, of medicine, of objective teaching.

Alcohol and Driving

I believe we can teach many basic facts about alcohol and its effect on the individual. For example, we can do a lot with the question of alcohol and traffic. High school students are eager to get a license, to drive a car. It is a golden opportunity to introduce material on the action of varying amounts of alcohol on reflexes.

I believe we should provide an opportunity for full and uninhibited discussion in the classroom about this question of drinking. I have said that a negativistic approach is not psychologically sound. Attacking drinking customs is not necessarily the most effective approach. Boys and girls are going to get information about drinking from some source. It may not be the kind of information that makes sense to the adult. It must be at the level of young people because that is the only kind that makes sense to them and their friends.

I think we need to consider the needs of young people—to be accepted, to be popular. Is it sophistication, or is the boy who insists on engaging

in a bizarre drinking episode indicating his insecurity, his feelings of inadequacy, by trying to attract attention?

As far as grade placement is concerned, I don't think we can do very much in the early grades other than to incorporate it with information about eating and drinking habits. For young children certain foods, certain drinks are not recommended. At the secondary grades we can do more. I don't think there should be any formal courses. I don't know where you would place a formal course. We have had enough compartmentalization of education as it is. Wherever possible alcohol instruction should be integrated with other courses. Now I recognize some of you are thinking that integration of teaching leads to incidental teaching. This need not be the case. We can furnish teachers with material in which they have confidence, material which will evoke an active response from students.

The Positive Approach

How far do we go? I think we should start teaching at the point were the students are, not where we would like them to be. There is a challenge in this type of teaching which is being met in many schools in such courses as home and family living, home management courses for boys and girls, questions about the function of the family, of society, the role of parents. Such material is being introduced in schools around the country. We can encourage consideration of the advantages of abstinence for young people rather than the threat of drinking. Actually the threat to young people is not insanity, not cirrhosis, not alcoholism. The real danger for young people is intoxication. At an age when physical and emotional balance has not been established, when spurts of one kind or another occur, when there is tremendous concern on the part of many people over emerging adulthood, we may well hesitate to introduce into the system a chemical which may retard their advance to emotional balance.

Interaction in Classroom

We can only achieve open-mindedness in discussion of alcohol questions in the classroom when we give up the traditional assignment, question and answer approach and rely on group interaction. There is evidence that young people in a permissive atmosphere will be completely honest, will be completely relaxed in expressing opinions. When the teacher accepts her role as group leader, when she is willing to give up her authoritarian position, when she is willing to place confidence in the group to direct its discussion into constructive channels, I believe that results will be illuminating.

The World Health Organization Expert Committee on Health Education of the Public stresses the importance of motivation in learning, including the need to satisfy goals and interests and the significance of the group approach. "People are interested in doing those things which seem to help them achieve something they want, or to cope with their own specific problems." The health educator who recognizes this characteristic of learning will not ask, "How can I motivate people to learn about health and to change their health practices?" Instead, he will be concerned with the goals and purposes of the people; how he can help them obtain their goals, and perhaps see a relationship between some of their goals and improved health practices.

The use of alcoholic beverages has persisted in our culture because it serves a function and presumably as-

(Continued on page 31)

Why must the alcoholic - - -

Surrender?

by
Vernelle Fox, M.D.
Medical Director, Georgian Clinic

A GREAT deal has been written and said about surrender in the recovery of the alcoholic. Sometimes in a group I use this word, "surrender," and I can see the cold chills run up and down the back of the novice. Surrender means defeat. Surrender means giving up when one is fighting it. When you are fighting you are called upon all the time to defend yourself against almost anything and everybody. This really isn't what surrender, in terms of alcoholism, truly means. This isn't what Dr. Harry M. Tiebout, the noted psychiatrist, says when he uses the term. By surrender he means a willingness to give up a pathway of destruction, a self-willingness, of defiance that keeps you out of tune with the rest of the world.

It is only true surrender, and by surrender remember that we mean simply giving up one way in order to learn another way—that an individual is freed to grow strong. Through surrender you may find yourself emotionally naked and afraid in the beginning. Later you are freed of the old fixed ideas of having to fight it out your way and completely freed to look around at the rest of the world and pick and choose the techniques and the defenses and the ways of thinking that make it possible to live comfortably with people. It's really quite nice not to have to be on top—not to have to always be right—not to have to be on the *defensive*. You can feel "I am one person, among many, with the absolute right to my own feelings, but with no necessity of being the only one who is right." Only through defeat does the average champion grow strong and become freed of his pre-occupation and able to develop all the multitude of things that he *can* do in life.

You see, when you are completely consumed with trying to prove the unprovable, which is that you *can* drink alcohol without getting into difficulty, you are helpless. It is only when you are freed of this that you are able to look at all the other things you can do, including "don't have a drink if I do not want to." After the "cannot drink if I don't want to" is settled, you're totally free and capable of doing many things that in the last few years you have not been able to do.

This may sound quite simplified and elementary, but it is probably the one insurmountable step that trips up more alcoholics than any other. Somehow he hangs so long and so steadfastly to the idea that he must conquer alcohol, that he completely drops the ball for all the other things that can be conquered, can be worked out, and be produced in his life. When fighting the difficulties of "how can I give up without being defeated," remember that to give up in one small area may free you to take over or to be victorious in all the other areas in life.

SELF DISCOVERY

FAI

Smiley

Only through our search
we find true happiness in a life

EVERY person's emotional history is a delicate thread of individuality woven around the common spool of humanity. Although the need for love is universal in mankind, there is infinite variation in the sensitivity with which we respond either to its gratification or its denial. Everyone faces the task of curbing his agressive impulses; but we differ constitutionally in the strength of our primitive drives, and for some of us the problem will always be less severe than for others. Fate, too, refuses to play its role twice in exactly the same way, so that even members of the same family often develop opposite traits of character and personality.

Nevertheless, in one significant respect we all share the same psychological destiny: All of us emerge from the period of childhood with a partially distorted view of life. As a corollary, adulthood confronts each of us with the same psychological obligation,—we must all engage in a process of self-discovery before we can correct these false views and achieve the ultimate victory of mature love.

Now there is a mistaken notion current that only those fortunate enough to escape conflict and frustration in childhood can ever hope for true happiness in later life. Such a view reveals a basic misunderstanding of modern psychiatric discoveries, as well as of the meaning of life itself. For childhood, by its very nature, compels all of us to misinterpret reality and to store up grievances that have no foundation in fact. It does not matter how fortunate may be the actual circumstances of our early years. Nature itself drives every child to be insatiable in its demands for love, to exaggerate every rebuff into a mortal injury, to respond with murderous hate when its will is oposed. These reactions, born

From "Love or Perish" by Smiley Blanton, M.D. Copyright 1

ton, M.D.

these universal needs can
t comes face to face with reality.

of the child's lack of conscious knowledge and experience, inevitably leave a residue of unconscious resentment, fear and guilt. A childhood without such misconceptions would be, in fact, an abnormal phenomenon almost beyond imagination.

It is important to remember that every normal life must include conflicts, fears and anxieties. Adolescence and marriage, parenthood and middle age—each new phase brings new tensions and requires new adjustments. We do not become ill and unhappy because these everyday problems arise, but only when we fail to *solve* them satisfactorily. In the same way, the false views of childhood are a normal outcome of our early experience. They become stumbling-blocks in later life only if we persist in holding on to them *as if* we were still children.

To hope for the elimination of conflict and frustration is a foolish fantasy which violates both scientific theory and common sense. Psychiatry has given us new insights into the *origin* of these problems that we may be better equipped to dispose of them when they occur. It has provided new tools and directives, that is, to aid us in the task of *coming to terms with reality.* This is a significant enough contribution—but the task itself has faced mankind from the dawn of history and will continue to do so at every turn along the path of life.

What are some of the directives offered by psychiatry to help us in this process of self-discovery and adjustment to reality? What are some of the steps we can take to release our energies in the fullest service of love?

Foremost among these, in my experience, are three which have virtually universal application. They are the following:

1. *We must forgive our parents for*

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the injustices—both real and imaginary—we received in childhood.

Who can look back with wisdom upon his early years and not concede that in many grievous ways he had failed to understand and judge his parents properly? Childhood is an age first of overemphasis and exaggeration, then of rash rebellion, and often later of casual indifference. All of us began by endowing our parents with godlike qualities both of good and evil. When they gave us love, we exalted them to the company of angels; when they ignored or punished us, we turned them into demons. As children, we could not know that our parents, too, may have been torn and harassed by the burden of life; that others in the family may have had equal claim to share their strength; or that we ourselves may have demanded what was beyond their power to give. We expected infinite love and perfection of them, and we interpreted each lapse as a sign of injustice or treachery.

A Distorted Image

Every person's original image of his parents is thus based in part on a distortion of reality. The picture is overlaid with additional errors when, in our later bid for independence, we condemn all our parents' ways as wrong and outworn in order to justify our own new paths. It is natural enough for us to do so. But by the same token we accumulate a mass of grievances, resentments and hostilities of which only a small number, as a rule, have genuine validity.

Psychiatry teaches us that we must unburden ourselves of these false resentments if we are to become lovable and loving persons in our own right. For our attitude toward the world is modeled upon the inner image of our parents that we carry in our hearts, and our feelings toward other men and women are automatically governed by the love or hate which predominates in this inward vision of our fathers and mothers. If we stubbornly shroud the remembered portrait in the dark draperies of ancient grievances, we condemn ourselves to behave toward others like a disgruntled child who shuts himself off in a corner, where he wallows alone in gloomy self-pity and hurls malevolent glances of vengeance at his imagined oppressors.

Both wisdom and self-interest dictate that we come out of these shadows and stand in the tolerant light of maturity. Our normal course must be to identify with our parents, to see with their eyes, to suffer with them what was their own lot of hardship and trial—yes, and also the injustices they themselves in an earlier day may once have received. Then our childishly rigid "I accuse" will be withdrawn, and in its place will come the adult's tender "I understand." We will then be able to dwell with gratitude upon that measure of genuine love and care that our parents in reality bestowed upon us.

ABOUT THE AUTHOR

Smiley Blanton, M.D., was one of the first psychiatrists in America to recognize the joint effect of religion and modern psychiatric insight. Co-founder in 1937, with Norman Vincent Peale, Dr. Blanton is Executive Director of the American Foundation of Religion and Psychiatry with clinic and headquarters in New York City. He was educated at Cornell University Medical School, worked at Johns Hopkins, organized and directed mental hygiene and child-guidance clinics and in 1929, traveled to Vienna to be psychoanalyzed by Sigmund Freud.

His book, "Love or Perish" has been on the best-seller list since its publication in 1956.

In a spirit of forgiveness, we will see how little, after all, there was to forgive—and how much to be cherished!

Every distorted segment of the past that we bring into proper focus automatically makes our present vision more sharply attuned to reality. When we forgive our parents, we free ourselves of the neurotic need to demand "restitution" from the men and women who later replace them in our hearts. We no longer will expect the whole world to love us by way of compensation, nor will we retreat in sullen despair when signs of human frailty appear in those who do give us their love. We will learn, instead, to seek out the good and to preserve it with renewed tenacity. Thus our tolerant *inward* view will be reflected in *outward* benevolence, and thereby lead us to recapture the love we once deemed lost.

2. *We must have faith in a universal power greater than man's—the source of life and love.*

Of all human emotions, perhaps the most devastating is the feeling that one is alone in the world. The abandoned child, the ostracized member of a group, the rejected outcast of society—none is so desolate as the person who feels that he is isolated, unwanted, or without some relationship to any other living force in heaven or on earth. For the essense of life is love, the essence of love is union; and no man can experience love who has no object outside himself with which he can join.

Search For Love Object

All of us spend our lives in a constant search for such an object. We find it at first in the parent of our infancy, but as we grow up we transfer these feelings of love elsewhere. I have previously shown that in every phase of life we find a series of substitutes—in our work, in our social relationships, in the families we ourselves establish when we attain maturity. On a large scale, society itself emphasizes the need for us to merge with outside groups, for it is through union with others that we "bind" our aggressions to love and thus bring them under control.

Yet experience teaches us that human bonds are fragile, and even the strongest of them may be snapped without warning by death, violence or the tyranny of fate. Moreover, mankind as a whole feels the need to ally itself with a beloved object, and it is here that we can all join together to hold a common faith in that force we call God, or the power which regulates the unfathomable workings of the universe.

Religious Wars

In the name of religion, men have wrangled over creeds and fought over theologies, each convinced that his own is the one true revelation. All through history, too, different peoples have held different official concepts of God, and have even waged war to support their beliefs. Yet, underlying all these varieties of creeds and religions, one basic concept has always predominated. It is the view that there is a universal power greater than that of man's, and that we must have faith in it as the one sure anchor that will support us throughout life.

Some find this manifestation of God in the infinite distances from star to star. Others see it in the eternal cycle of birth and death, of day and night, of summer and winter —overwhelming phenomena all, and recurring endlessly despite what individual man may do. Still others obtain their understanding of God through the teachings of their church, each according to his own convic-

tions. But all are united in the realization that the vast universe, with its baffling multiplicity of miracles, is beyond mortal comprehension. St. Thomas Aquinas declared: "Every mind must face the rebuff of mystery." Even the wisest of men have always had to be content with but a fragment of the whole truth.

An Inner Security

In the face of this mystery, we can overcome our ultimate loneliness only by a feeling that we are a part of the great design that controls the universe. We do this by transferring our love and faith to God, and thus achieving an inner security that transcends all human failings—the "peace of God that passeth all understanding." In my experience, it is through this faith that we obtain our most powerful sense of love, of receiving love, and of being at one with all humanity.

3. *We must accept our own aggressive impulses as a natural and normal part of life.*

It is not often that men are brave enough to peer into the secret labyrinth of human nature and remain unshaken by the dark spectacle they behold. "We all have feelings inside that would shame hell!" declared the gentle Robert Louis Stevenson with a poet's courage; yet for the most of us the subterranean mind of man has in the past presented far too frightening a picture to bear any but the most timid scrutiny. In our unconscious lies all the primitive fury of the elements, all the fierceness of the jungle beasts, all the cruelty of the naked savage. Mankind has spent millenniums of patient effort to build a veneer of civilization around this primitive core, and one easily understands our universal reluctance to pry beneath the protective cover.

Cilivilzed morality consists of the legal and ethical barriers erected against these primitive aggressions. Mankind has always required an authoritative voice of restraint to prevent the wild anarchy that would follow if the grosser crimes of murder, incest and cannibalism were left unchecked. We see the wise necessity for these proscriptions when our children in miniature repeat the historial evolution of the race. Every wise parent knows that at certain crucial junctures we must mark out the proper way of life with firm precept and command. That is how the child develops its moral conscience, its sense of justice and integrity, and hence its ability to win an acceptable place in society at large. Yet too often we pay a severe price in individual unhappiness for the social law and order obtained in exchange. Some of this unhappiness is perhaps inevitable; but psychiatry reveals to us that much of it can be avoided. For in its zeal to impress its desirable precepts upon men, civilized morality has often unnecessarily denounced our aggressive drives as "evil", and insisted that we abandon them on pain of eternal punishment. By relegating these impulses to a criminal underworld of "sin", it has caused men to turn aside from their contemplation in shame and fright.

Purging Evil Spirits

Men once had this attitude toward physical disease. They used magical threats and prohibitions to banish the "evil" spirits that afflicted their bodies—but the microbes did their deadly work nevertheless. I believe our moral evolution is rapidly reaching the point where we must face the psychic realities of human nature with the same calm objectivity we have learned to use in probing man's physical nature. To the tried and true morality of the past, in other words, we must now add a more mature *method* that will put its teachings

into better effect.

Modern depth psychology has taught us this: Man's elemental drives do not vanish by themselves simply because we may ban them as "vicious" or "immoral." When we do not acknowledge to ourselves the existence of our own primitive impulses of aggression, we often develop a neurotic sense of guilt. To shake off this guilt, we unconsciously either punish ourselves with wasteful failure and illness, or we "project" our own emotions into other persons and accuse *them* of the hostile feelings we ourselves bear in our own hearts. We thus use our aggressive energies to create imaginary enemies where none may exist, and so plunge ourselves into futile conflicts.

Mankind must learn to accept the psychological truth that *there is no inherently evil side to human nature.* We begin life simply with the energy derived from our primitive impulses of love and aggression. Every bit of this energy is potentially useful and valuable in itself. We must learn to study the nature of these forces within ourselves and look upon them with equanimity if we wish to obtain effective control over them. To recoil in fear from their elemental power is to become their victim instead of their master. The real "evil" comes when through willful ignorance we avoid the truth; the real "crime" occurs when we fail to use love as a guide which will direct these primitive energies to constructive ends; the real "immorality" is worked when we alloy neurotic guilt to distort their useful power into destructive hate.

Admittedly, it will not be easy to accept self-discovery and self-control as the pathway to love where men have been accustomed to rely on external warning and authority. Yet the effort must be made, for we never truly possess love unless we possess it of our own free will. The frightened, neurotically guilty man is a loveless man, however diligently he may obey the laws of good conduct. We now know, however, that our greatest fear is always of ourselves—but only of that which is *unknown* or *concealed* within ourselves.

Long ago the great poet Friedrich Schiller said: "There is no freedom but love." To this the voice of modern psychiatry may add: "There is no love but truth!" *Self-discovery, Faith, Truth*—through these we bring love into our lives, ourselves become loveable, and so reach out to forge with our fellow man the enduring bonds that preserve life.

A GUIDE TO BEHAVIOR

Modern psychiatry teaches us that we fall ill, emotionally and physically, if we do not use love to guide and control our behavior. When we cannot give and receive love freely, we become easy prey to the dread emotions of fear and resentment, of anxiety and guilt. These diverse expressions of hostility so distort our outlook that we are then unable to view life in a clear and objective manner. Fear paralyzes our natural impulses to explore and investigate, while resentment causes us to misinterpret what we see. Anxiety prevents us from accepting the normal experiences whereby we grow and develop to our full potentialities. Guilt, in turn, forces us to punish ourselves with accidents and faulty actions that lead to unnecessary frustration and defeat.—Dr. Smiley Blanton.

THE core of the treatment program at the Alcoholic Rehabilitation Center, Butner, North Carolina, is the group psychotherapy program. During the 28 days that a patient stays at the Center, he attends an average of 24 group therapy sessions of an hour to an hour and a half in length, preceded by a film which is intended to set the keynote for the following therapy session.

We have eleven films and a bi-weekly "gripe session"; after the cycle is completed it is begun again and each patient has the opportunity to view each film twice during his stay, partly because he is not always able to absorb all the implications of the film when he first comes in, and partly because successive viewings bring out new details which would be missed the first time.

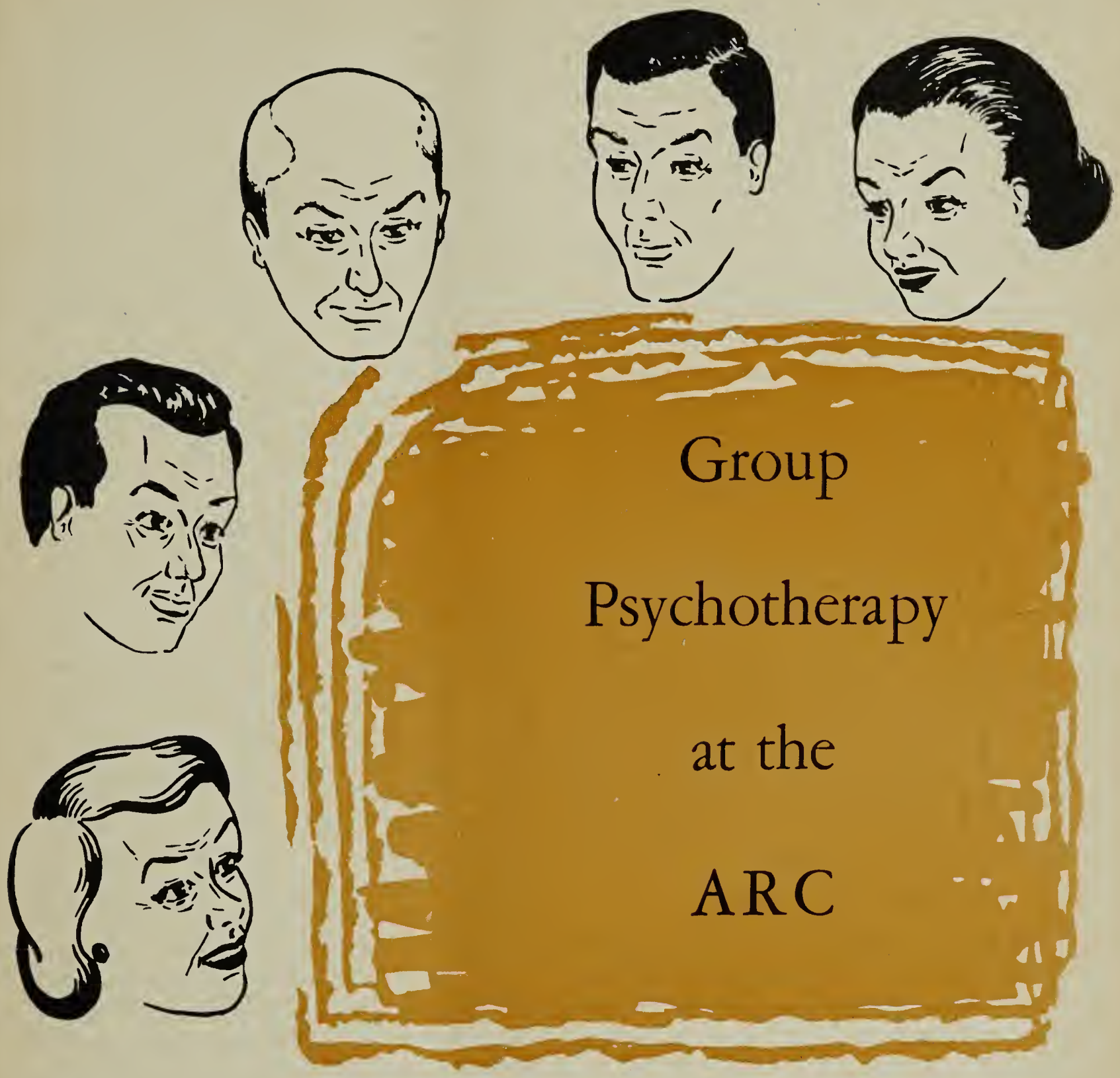
Out of our eleven films, only three at the present time have to do specifically with alcoholism; the other eight are related to the basic problems of being a human being, common to all of us but perhaps particularly pressing for the alcoholics. The alcoholism films describe the course of the development of alcoholism, give a personality picture of a rather typical alcoholic, and impart scientific information about the effects of alcohol on the human body. The other films, those on interpersonal relations, have to do with such problems as the handling of hostility, dominant and over-protective parents, sibling rivalry, and other personality configurations which we believe to be typical of many individuals who find it difficult to handle the predicament of being human.

The therapy sessions following the movies are held by the several staff members who have close contact with the Alcoholic Center: Dr. Cathell, the hospital superintendent; Mr. Pulley, social worker; Mr. Barham, chaplain; Dr. Peter and Dr. Lokey of the medical staff; and myself.

The orientation of the various therapists are far from uniform, and the patients have the opportunity to hear many views expressed, to relate to the different personalities of the leaders of the groups. Methods of handling the groups range from the delivery of factual information to extremely non-directive permissiveness which places the patients squarely on their own; most therapists, however, use a middle of the road aproach which places the responsibility for the conduct of the group on both patients and group leader.

Role of Therapist

My particular part in the group therapy program at the Alcoholic Rehabilitation Center has been as group therapist once weekly, following two of our films on interpersonel relations, "The Feeling of Rejection" and "The Feeling of Depression." Most of us who have been in the field of mental hygiene are familiar with Margaret, the dolorous heroine of "The Feeling of Rejection." This is a little girl who was disastrously over-protected by her mother, forbidden to undertake such normal childhood activities as swinging on the garden gate, climbing banisters, handling sharp instruments—all because of her mother's excessive and neurotic fear that she might injure herself in some way. A sister arrived on the scene and a problem of sibling rivalry developed in which, try as she might, Margaret never could succeed in competition and was even scolded for attempting to do so. The film goes on to show the unhappy effects on her adolescent life as she fears to compete with other girls for boys' attention and with classmates for the limelight in school productions. We see her finally as a dowdy, drab, listless young woman who dares not lift her voice in dissent, who can



Group Psychotherapy at the ARC

by

Janet Haas

Clinical Psychologist

Alcoholic Rehabilitation Center

Butner, N. C.

What is group therapy and what does it mean to the patient who is finding it difficult to handle the job of being human?

be bullied by the meekest sales clerk, who has no available will of her own, and can only express her helpless, hopeless bottled up feelings of frustration in psychosomatic headaches.

It is my feeling that "The Feeling of Rejection" is one of the most productive films that we have, partly because of a sense of proprietorship, no doubt, but also because in my experience with alcoholics, I feel that the inability to say "no" to others, being "too good for your own good", being too easy going, doing anything for anybody, either to avoid an unpleasant scene or in order to win approval—is a tragic and all-to-common problem faced by our alcoholic patients. All of us have a deep need to be approved of, and to have a sense of belonging; these things are vital to our indispensable sense of self-esteem. We will make many sacrifices for this feeling of belonging, but at times the price we pay in dignity and in self-respect, in basic integrity and honesty with ourselves, runs far too high for the counterfeit approval which we earn thereby.

Mask of Anonymity

Although it is difficult for anyone to open up and admit his problems, it is often easy for a patient to talk about Margaret when he is really talking about his own problems, thus taking advantage of the mask of anonymity. Usually during a discussion of Margaret's problems we talk about the basic needs of a child not only for protective love and security, but for a basic sense of self-respect and confidence, the courage to explore a new and bewildering world. Although it is most common that the title "The Feeling of Rejection" is seen to apply to the sibling rivalry situation, there will always be someone in the group who can be depended upon to see that Margaret was rejected even before Virginia was born, that her basic selfhood, her need to be a free and independent individual was denied by this nervous and overprotective mother. The film is a difficult one often for women who have children to view and discuss, for all of us have normal anxieties about the welfare of those for whom we are responsible and we all tend to be overprotective from time to time. It is natural for us to wish to defend this pattern of behavior against all criticism. Nevertheless, it is my feeling that in order to learn to hold close with open hands, we need to evaluate some of our old rigid patterns of behavior.

Can't Say "No"

The discussion usually goes on with the implications of never being able to say "no", with possible ways of standing up for oneself in a socially acceptable fashion, with the modifications that we might bring about in our childlike attitude that it is always wrong to speak up to authority figures. Most of the time we bring up the question of the way Margaret might react under the influence of alcohol and nearly all the time agree that she would speak her mind, would not let people run over her and impose upon her. This particular film shows Margaret going to a psychiatrist and through group therapy gaining the ego-strength to stand up for herself, finding in psychiatry, in a much more socially constructive, valuable, and long-lasting fashion, what some people find in a bottle.

It is the general orientation of the Alcoholic Rehabilitation Center that if one can in some way manage to act drunk while one is sober, to find ways of doing things while one is sober that could only be done before with a few drinks under the belt, that the need for the crutch of alcohol would be greatly diminished.

John, the unhappy hero of "The

Feeling of Depression" was the older of two children of a severely ill mother who died early in his life and a hard-working somewhat duty-bound and rigid father. When John's mother became ill, she started to reject him because she couldn't be bothered, and finally when she died this was apparently perceived as the greatest rejection of all. In the meantime, Bobby, John's brother, had intruded in his family idyll and he could never find an acceptable outlet for the normal feelings of resentment which siblings will develop at such a time.

A Destructive Symbol

A vivid scene in the film takes place when Bobby destroys a snow-house which John has lovingly built to show to his father, symbolizing the destruction of the home which John feels Bobby has brought about. He beats Bobby unmercifully but in return receives a severe thrashing from his father who makes no attempt to understand what John's problems really are. These problems are further confounded by a shrewish and antagonistic aunt who seems to adopt also an anti-John attitude. John has nothing to do with his hostility but to swallow it up, to turn it into its exact opposite, and upon the occasion of his father's death, embark upon a career of doing for his younger brother what parents would ordinarily do.

In becoming a second father to Bobby he sacrifices many pleasures himself, adopting the same martyred attitude as was shown by his father, and finding what little happiness he gets in life from the vicarious satisfaction gained from his brother's success. However, when Bobby began to succeed on his own at college without needing John and especially when he began to get from life some of the gratifications John had been deprived of, such as love and marriage on one hand and success at the writing career John so deeply but fruitlessly had yearned for on the other, the sweetness of John's satisfaction turned to bitter gall. Unconquerable feelings of jealousy and resentment arose in John but since he had been so thoroughly punished for any hostility toward Bobby, since he had been threatened with the ultimate of all punishments, the loss of love, for any expression of anger toward his brother, he had nothing to do with his anger but turn it in upon himself.

We then saw John as a self-punishing guilt-ridden individual, a man who would not permit himself joy or the full experiencing of life, an individual who blamed himself for all events great or small of an unhappy nature. This film ends on a more ambiguous note since it only hints that John could receive help from therapy and does not show him actually doing so. Perhaps because of this ending it leaves one with a rather empty feeling and an all-too-clear feeling of depression.

Valuable Insight

However, the understanding that is offered by this film of the dynamics of depression, of the way that depression is related to hostility, is extremely valuable, as well as is the opportunity to explore further the implications of sibling rivalry. In both of these films we have the opportunity to investigate the psychological meaning of being the oldest child and also the psychological meaning of being the youngest child. In this way many people are given the opportunity to bring up their own personal situations without feeling compelled to do so.

It is the personal orientation of this writer that there is no great barrier, no chasm, between the alcoholic

(Continued on page 31)

My Dear Drunks

LET me make clear that I am no "authority" as a pastoral counselor or what is now known as "clinically trained"—simply "experienced" over a period of fifty-nine years of actual counseling as a clergyman of the Protestant Episcopal Church. I had for many years, however, Dr. John Rathbone Oliver and Dr. Smiley Blanton as patient mentors. There was a short break when on January 1, 1947, I retired as Dean of the Cathedral of St. Philip in Atlanta, at the age of seventy, but only officially since a very wide acquaintanceship kept me almost as "busy as usual" in the counseling ministry; but in April, 1954, I was appointed Director of Religious Therapy at the Georgian Clinic for Alcoholics in Atlanta. In the spring of 1958, I retired from my position at the Clinic in favor of Dr. Charles Hall who has been thoroughly and clinically trained for his work; but I have continued counseling with patients.

My first alcoholic patient was a solitary and lonely secret drinker sixty years ago while I was a young missionary in the mountains of Tennessee. He drank strictly "off the job" and had been doing so for about a dozen years. He was not taking the proper care of his family and the situation was becoming desperate. He, himself, also, was close to despair. He came to see me and begged, "Please for God's sake, help me!"

"I'm sorry," I answered, "but I'm afraid that I can't" and I meant it. His condition obviously was beyond anything I knew how to do, an inexperienced theological student not quite twenty-one, not yet ordained.

He stood up and said bitterly, "And you call yourself a minister of the Gospel! Goodnight!"

I stopped him from leaving and said quietly: "Yes, but that is all—a minister of it. I believe the Gospel. If you are willing, we shall pray here and now to the Great Physician, together. Kneel with me and put your trust in Him."

He did kneel with me, a gaunt six-footer and joined me in simple, earnest prayer. He told God of his habit and his longing to be free of it, as a child might pray. We said "Amen" together and he stood straight, his face illuminated, and said joyously, "It's gone."

I lost touch with him after twenty-seven years; but he had never taken a drop in all that time, since he "took it to the Lord in prayer," as he expressed it. He bought and paid for a good home, gave each of his children an excellent education and started them on successful careers—they were all boys. He had become very devoted, calmly happy and thoroughly dependable.

That experience colored my whole approach to the problem of alcoholism and while it should probably have made me depend entirely on religious conversion, it did not. On the contrary, it made me think seriously in terms of what I have learned to call "etiology, diagnosis, prognosis, therapy and prescribing" with an even deeper religious implication. I recognize, of course, that all the healing arts are a gift of God and that even where there seems to be a lack of "consecration" there is no lack of "dedication" and that the

Raimundo deOvies, D.D., Lit.D., L.L.D., a retired clergyman of the Protestant Episcopal Church, writes of the alcoholic in plain, understandable language from a background of experience culminating in 1953 with his appointment as Director of Religious Therapy, Georgian Clinic, Atlanta. Reprinted from "Dear Drunks" by Dean Raimundo de Ovies, Herald Pub. Co., Atlanta, Copyright, 1958.

latter is a necessary proof of the former. It is energizing the spirit towards practical demonstration.

Atlanta's great clinic and rehabilitation center is a clinic in every respect. It recognizes religion as one of the indispensible therapies, and does so without reservation—except as a substitute for any of the others employed; but, conversely, we ministers on the staff cannot accept any or all of the other therapies as a substitute for religion. This is clearly understood by the other staffs and results in harmonious cooperation and increased efficacy. It is "multiple therapy" in a broad sense and results are encouraging.

In religious therapy, which is my field, the nature of it is so intensely personal that variations in the techniques of the pastors working with the clinic's patients are to be expected and more than "countenanced"—they are considered an asset because of the amazing variations in personality among the patients. Besides, while the background and training of the ministers themselves are to a large extent similar, they are not all of the same church or denomination. However, the motivation of their work is identical and points of agreement greatly excel any difference of opinion. That motivation, boldly stated, is: The restoration of self-respect, faith, and a definite and firm purpose in life, by God's help. All therapies then take on life and vigor.

Established Rapport

As for my own work in this field of "pastoral psychology", I may speak for myself only and offer it for whatever it may be worth. First, to establish *rapport*. A long and rich experience in dealing with persons of all ages (including much baby-sitting) in Boy and Girl Scout groups, teaching in private school, high school, college and seminary, counseling with both parishioners and transients, has developed a quick and intuitive attitude of friendship, until, as an old man, I can sincerely claim that I have realized that "God is no Respector of persons," and that we are all, without any exception, children of God. The pastor, like the family physician, has an enviable advantage in winning relationships.

Establish Communication

Second: to establish communication. This entails the stimulation of articulation in the clients, and self revelation. The counselor needs to know the client's life story in order to appraise the situation, which means, of course, that the counselor has learned to listen, commenting at first only to stimulate free expression. In spite of what may be already known about the client, the counselor must learn it "at first hand" and must also sift the wheat from the chaff of any rambling or disorganized presentation of the client's problems. Also, a great aid to a counselor is a detailed report of the receptionist and other members of the staff and the diagnostic report of the psychiatrists prior to any interviews with any particular patients; and the pastor-counselor acquaints himself with the medical diagnosis, as far as it can be understood by a layman.

Now, it is possible for the pastor-counselor not to *preach,* but to *listen intelligently* and discriminately, to determine the possibility of rendering help in consideration of the damage already done to the personality of the patient.

Our clients do not need preaching during a counseling session and at least some of them know more about "the wages of sin" than we do. Therefore there is no scolding or condemnation. We tell of the loving kindness of God and of forgiveness. One of our

most difficult tasks, frequently, is to persuade the alcoholic man to forgive himself; and that goes double for alcoholic women!

Presuming that the desire for sobriety is genuine and sincere, we know that our patients have an exceedingly difficult struggle to face and we sympathize but never condone. We do not accept any reasons offered for acquiring the addiction, while fully aware that there may be a multitude of causes.

I have trained myself to be positive in my attitude towards counseling with alcoholics and to avoid negative suggestions. I cannot remember ever asking a patient to stop drinking. The emphasis is always on the possibilities and strong hope and determination to become and remain sober. I seek to discover the patient's gifts, talent and abilities and to encourage their development and use.

Since I consider my work as chiefly pastoral I try to convince these men and women that they are the children of God—and that we love our own children, not because they are perfect but because they are ours. Pastoral counseling is an art and a field in itself. It's underlying motivation and power is "old-fashioned" saving Grace; and I have observed it far too often to doubt its availability even in "these days."

After more than fifty years of listening to people's problems, mental, emotional and spiritual and of using the limit of such knowledge, experiences and wisdom as I possess, I am still profoundly startled over the superior types of persons who become addicts to alcohol, narcotics and other means of including "forgetfulness" or other feelings of false security that give temporary relief from anxiety, conscience or facing life realistically.

Many of our patients are unusually gifted persons, with extraordinary capacities, many of them likable, persuasive and to whom it is difficult to deny favors. Some are superb salesmen who attempt to sell nothing but themselves—and who succeed for only a short while because they soon lose their "customers". I fall easily for such at times—for a while. Then I frankly tell them the truth about themselves. Their knowing it is the first step in rehabilitation. I do not criticize, scold or condemn. But "the truth shall make you free" is sound therapy and liberation, if either is any longer possible; and my own attitude is that nothing is impossible with God. Neither medicine, psychology nor psychiatry are my fields of knowledge, training or work. Religion —in a very broad sense is, and has been for sixty years. I realize it is possible to live without religious faith —but how?

Number One Illness

Much publicity has been given lately to the fact that the number one health menace in the United States is mental illness in some form. It is estimated that one out of every ten persons born each year becomes a mental casualty, treated or not treated as the case may be; unfortunately, there is no provision either in space, equipment, money or psychiatric treatment or care; and, more unfortunately, very many curable or amenable-to-treatment persons receive no treatment at all—are not even diagnosed!

As in the instance of alcoholism, much of the abnormal thinking and behavior is self-induced, caused by controllable yet reprehensible conduct long continued; yet, even so, the condition becomes fixed, no longer subject to the will of the individual and we have a definite disease, an illness requiring medical and other remedial help. In alcoholic therapy I know of at least five professional

skills *necessary* for a reasonable hopeful cure, and others are useful and desirable. Our best hope lies in a period of institutional care, where all available therapies are available in one place. This is equally true of many forms of mental illness although some types may be treated successfully in the offices of psychiatrists or under psychiatric treatment in their homes. But treatment they should receive and the sooner the better.

Alcoholics Are Lonely

Of necessity, an alcoholic desires the respect, liking or at least the tolerance of some other person or persons, if only other alcoholics. Loneliness is a chief contributing cause of the addiction of a large percentage of alcoholics, and alcohol gives them a temporary compensation for real or imagined physical or personal defect. Although loneliness is a contributing temptation to resort to alcohol, there is a deeper reason for the loneliness; perhaps several reasons. Among these are: the feeling of *not belonging,* ignorance, inadequacy, "outclassed", inarticulation, failure, fear, lethargy, lack of initiative, etc. Such individuals can become easy victims of alcohol and its power to remove inhibitions.

Although an ordained clergyman for over half a century, I was not always one, and I have been in bars, bistros, pubs, rathskellers, saloons, etc., both abroad and at home. I have seen the taciturn after a few drinks become garrulous, and the reserved and uncommunicative "tell it all" to a total stranger. Most of them seemed to need some sort of aid. They definitely felt the need of either mild or catastrophic emotional reversal and relief from the numbing strain of their routine living.

There must be professional knowledge and confirmation to obtain an accurate diagnosis, either physical, emotional, or mental, and non-professionals, from the medical or psychiatric viewpoint, need guidance. Exaggerated or abnormal emotional reactions can easily be recognized, but the "why" of them cannot. *Why* and *how* are the tasks of psychiatry. Sickness is often mistaken for "sin" and conversely sin can and does become the forerunner of "sickness". Ministers are sometimes inclined to ignore the former. In our dealings with alcoholics we find that healing sometimes results in moral conversion.

There is still another difference between making decisions from facial expressions or other muscular reactions, and psychiatric diagnosis. The former may be either superficial or temporary as in the instance of a lively child passing through successive "moods."

Depth Psychology

A true diagnosis of mental conditions can be secured only through what is commonly known as depth psychology and this definitely is not snap judgment. It is, rather, a careful prolonged gathering of appropriate evidence and an equal and persistent sifting, identifying, and appraising. This is the briefest manner in which the procedure can be described. There is much more, of course, but this is sufficient to indicate that counseling is a serious responsibility and requires training and at least some understanding of other therapies which must be employed to restore health. Healing of emotional and mental disturbances, as in alcoholism, requires multiple therapy and a pooling of diverse competency and skills.

Alcoholics are suffering from an exceedingly complex disease which is physical, emotional and mental in its manifestations.

LET'S BE OBJECTIVE WHEN WE TEACH ABOUT ALCOHOL

(Continued from page 14)

sists some people in attaining certain goals. Acceptance of this premise as a basis for exploring questions about alcohol does not imply that the function or values involved are either worthy, or disreputable. Attacking drinking customs consitutes an attack upon the goals of many drinkers, goals which in themselves may be admirable. This usually results in rejecting the charges presented in the attack and strengthening defenses against future attacks.

A Challenging Approach

Such an approach to instruction in a controversial area is extremely difficult. It calls for a degree of personal maturity, objectivity, and patience of a high order. This procedure applied in the field of alcohol problems will be subject to criticism. Some church leaders will challenge it on the ground that it endorses the principle of relativity of morals. Some professional propagandists, on the contrary, will consider it lukewarm, negativistic, and unlikely to produce immediate results. Still others will feel that it condones "moderation" and as such espouses the cause of the alcoholic beverage industry.

It is difficult to comprehend how a public school administrator or teacher can assume any practice other than one of objective analysis of all the facts. This is not fence-straddling —there is no fence except the one erected by extremists. Rather there exists a continuum of fact and attitude which should be explored. This is the most constructive and probably the most productive approach that can be taken in the classroom.

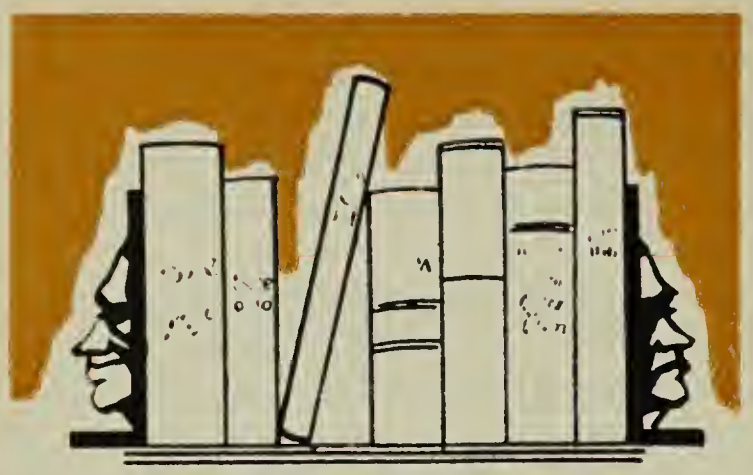
GROUP PSYCHOTHERAPY

(Continued from page 25)

and myself or any other individual. I feel that we are all in the predicament of being human beings, facing loneliness, fear, anxiety and frustration with the resources great or small which we have at our command. Some of us turn to one solution and some another; some turn to alcohol but others turn to drugs, religion, preoccupation with success and money, etc. It seems that when a person has a large repertory of resources at his command to meet life's problems he is better adapted for life than an individual who turns to the same answer no matter what problems there are which might come up.

No Problem Solver

Reliance upon one solution, the solution of alcohol, is therefore a rigid and non-adaptive way of meeting life's obstacles, but by far and away not the only maladaptive resolution of the human dilemma. Therefore I do not feel that because I am not an alcoholic I cannot help my patients; it may be true that I do not know how it feels to have convulsions, D.T.'s, social disgrace nor the physical and psychological effects of a hangover. However, the basic human feelings of which alcoholism is only a symptom are common to us all, and I feel, as do fellow explorers of the human problems, that not only can I be of assistance to my patients, but very often they are of equally profitable assistance to me as I, too, come face to face with life.



Books of Interest

AA COMES OF AGE

Alcoholics Anonymous
Publishing Co. Inc., N. Y.
324 pp., $4

THOSE who are interested in a detailed report of the history of Alcoholics Anonymous in this country will want to read this new AA book. A more complete anthology than the Blue Book, this new collection of messages from alcoholics and their friends gives a clear and concise picture of the growth of AA. The slant here, however, is entirely different from that of the Blue Book; it is less concerned with the personal histories of their contributors, and more concerned with AA as an *organization,* a fact which is becoming more and more evident, even over the protests of those older members who say that AA is not an organization, but a Fellowship.

The first part of the book, presents a panoramic sketch of the St. Louis Convention of July, 1955, at which time AA commemorated its twentieth anniversary. Bill W., co-founder of AA, remembers those three days as among the greatest experiences of his life and writes in glowing terms of his good friend, Dr. Harry Tiebout, reminisces about the hard times he had with Marty and Grennie and of their remarkable recovery, quotes Dr. Bob and Anne S., and Sister Ignatia.

The second chapter tells us of the three legacies of AA; Recovery, Unity and Service. "By the first we recover from alcoholism; by the second we stay together in unity; and by the third our society functions and serves its primary purpose of carrying the AA message to all who need it and want it." This section includes three talks, edited and enlarged, on the history of AA Recovery, Unity and Service, which were given by Bill W. at the St. Louis gathering.

The final and perhaps most interesting section is devoted to addresses of a number of AA loyal and devoted friends; Dr. Harry Tiebout, psychiatrist, Dr. W. W. Bauer of the American Medical Association, Father Edward Dowling of the Jesuit order, and Dr. Samuel Shoemaker, Episcopal clergyman.

Today there are over 200,000 alcoholics who have recovered through AA the world over. The growth of this remarkable movement is fascinating. How much this particular book contributes to one's understanding of just what AA is, is doubtful. It is obviously written for alcoholics, to be read by alcoholics and those familiar with AA. Novices looking for information about Alcoholics Anonymous would be sorely disappointed; it was just not meant for them. The entire tone of the book *assumes* the reader has a basic knowledge of AA and this is its chief fault. The fellowship of Alcoholics Alcoholics is something to be shared, yet how much do the names, Bill, Anne, Marty, Grennie, Lois, Bob, and others mean to someone totally unfamiliar with the people and stories lying behind those names? Very little or nothing. In order to overcome this difficulty, it would be wise to first read, *Alcoholics Anonymous,* the Blue Book.—*CC*

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the
Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program
On Alcoholism
7th & Woodland, Streets
WINSTON-SALEM , N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County
Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speaker—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—primarily for local public libaries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

JULY - AUGUST, 1959

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

On Giving and Receiving
Group Psychotherapy for Wives of Alcoholics
No Help Wanted
The Therapeutic Community
Alcoholism: The Public Health Approach
Alcoholics are Home-Made
Book Review
Letters to the Program
News From 'Round the World

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultatons with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a phychologist, social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

GEORGE H. ADAMS
Educational Director

INVENTORY

VOLUME IX NUMBER 2

JULY-AUGUST, 1959

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices Old Health Bldg., Raleigh, North Carolina.

CLAIRE CHENEY
Editor

ELEANOR BROOKS
Circulation Manager

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Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

NEW HAVEN: Twenty-one North Carolinians are attending the Yale Summer School of Alcohol Studies as recipients of ARP full scholarships. Once again North Carolina is one of the leading groups in number attending the Summer School. Scholarship holders are all professional people either working in the field of alcoholism or in some allied field.

CANADA: It has been announced that the 1960 annual meeting of the North American Association of Alcoholism Programs will be held in Banff during the week immediately following Labor Day

NORTH CAROLINA: The ARP held its 5th Summer Session on Facts About Alcohol at North Carolina College, Durham, and East Carolina College, Greenville, from June 9-19. The classes were well attended by North Carolina teachers and prospective teachers. Lecturers were Dr. Norbert Kelly and George Adams of the ARP staff, Dr. Fred Ellis of the University of North Carolina Department of Pharmacology, Dr. B. T. McMillon of North Carolina College and Dr. N. M. Jorgenson of East Carolina College.

ASHEVILLE: The Asheville Citizens Committee on Alcoholism and the Asheville Alcoholism Information Center are now "in orbit" with a monthly newsletter giving the news of their activities, plus other meetings and goings-on around the State. Titled "In Orbit", this month's newsletter carries the interesting news that Asheville has recently organized an Ala-Teen group, which is the first in the state and one of the first in eastern U. S. Thanks should go to Jerry McCord of the Alcoholism Information Center for getting behind this group.

RUSSIA: The January Reader's Digest reports Moscow Radio as saying: "In capitalist countries men drink from despair in order to forget how they are exploited, their bad working conditions, and the specter of unemployment. The alcoholism of the Soviet citizen has other causes. It comes essentially from the overflowing joy of living and from his tendency to celebrate with spirit the great achievements of socialism." Well, at least they admit that Russians drink.

NEW HAMPSHIRE: The fifth annual North Conway Institute was held June 15-19 at Stonehurst Manor, North Conway, N. H. This year's theme was "Pastoral Care of Alcoholics and Their Families."

LOUISIANA: From Baton Rouge comes the first of a new and informal newsletter published by the North American Association of Alcoholism Programs. The newsletter is designed to provide a means of communication within governmental agencies on alcoholism and between national health agencies and the NAAAP. It will be published periodically, as the need arises. Agencies with suitable news items which they think will be of interest to others in the field of alcoholism are asked to write the Editor, H. J. Walter, Box 4241, Capitol Station, Baton Rouge, La.

RALEIGH: Miss Roberta Lytle of the ARP staff has been notified that she is now a member of the Advisory Council on Christian Action of the Board of Christian Education, Presbyterian Church in the USA. Miss Lytle was selected because of her vast experience in the field of alcoholism treatment.

OHIO: Dr. John L. Norris, Medical Director of Eastman Kodak in Rochester, speaking recently in Columbus, emphasized that alcoholism, though a costly problem to industry, is a total community problem. He advised that industrial and civic leaders (1) inform themselves, their supervisory personnel and large segments of the public as to the real nature of the illness; (2) support the local Council on Alcoholism, particularly in regard to the establishment of a medical clinic with industrial relationships; and (3) develop a personal philosophy regarding alcohol and its use consistent with current knowledge and ethical considerations.

LONDON: "She was drunk, dead drunk — on nothing but water." This is the story two London physicians told in a report on nine Britons who suffer from the baffling ailment of excessive water drinking. It seems when a certain woman fell into a disturbed mental state she drank as much as 30 pints of water a day, even drank from a flower vase once out of desperation. Symptoms were similar to those of an alcoholic. Her enormous intake of fluid dilated the blood vessels, speech became slurred, eyelids drooped, she felt giddy and had the feeling of being in another world. Although this condition is extremely rare the nine patients in Britain suffering from this illness were enough to warrant a report in the quarterly Journal of Medicine. Next they'll be forming a Water Anonymous group.

NEW YORK: According to recent findings of the National Council on Alcoholism, the total Skid Row population in the U. S. is 500,000, of which 30% or 150,000 are alcoholics. Therefore, only 3% of America's alcoholic population of 5,000 are the stereotype "Skid Row drinkers."

Nursing Student Writes

I am a nursing student at Woman's College. A friend and I are very interested in helping and nursing alcoholics. We attended an AA meeting in Greensboro a few days ago and a member suggested that we write you and ask for the magazine INVENTORY. We are especially interested in the March-April issue which has several articles dealing with the nursing viewpoint.

Mrs. Evelyn Hollowell
Woman's College
Greensboro, N.C.

Says Magazine Helpful

Your magazine has been coming to me for a few years and I have enjoyed many informative and helpful articles. As superintendent of our church school I need the understanding and insight you give. Thank you for a magazine of this kind.

Mrs. J. M. Attkisson, Jr.
Garysburg, N.C.

Needs Information

I am a student at N. C. State College, taking Marriage and Family Living as a social science elective. In this class I took as my project "Alcohol in Marriage." I chose this subject because I think everyone needs to know something about the problem of alcoholism before he can understand it thoroughly. I would appreciate any help you can give me on this subject.

Joseph T. Johnston
Raleigh, N. C.

Requests ARC Particulars

I am working with an elderly woman who is an alcoholic and am anxious to recommend the N. C. Alcoholic Rehabilitation Center to her. I shall be grateful therefore if you will send me full particulars on the Center.

Reverend William Finnegan, S. J.
Loyola University
Chicago, Illinois

Doctor Wants Inventory

We would like to obtain two copies of each issue of INVENTORY to be placed in our Outpatient Department for use by patients and their families in that setting. Would it be possible for us to obtain these subscriptions?

Dan A. Martin, M.D.
Instructor in Medicine
Univ. of N.C. School of Medicine

Inspiring Issue

Having read your issue of the INVENTORY for May-June and found it so inspiring and educational in regard to AA, I would appreciate your placing my name on your mailing list. I am a member of a 12th Step House group. We help the down and out alcoholic in every way we can.

Anonymous
Buffalo, N. Y.

VOL. IX, NO. 2 INVENTORY JULY-AUGUST, 1959

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

GROUP PSYCHOTHERAPY FOR WIVES OF ALCOHOLICS

Two psychiatrists find that therapy for the wife not only helps her, but aids in hubby's recovery.

BY CLAIRE CHENEY

"Alcoholism is a family illness."

This was the discovery made by two psychiatrists at the University of North Carolina School of Medicine at Chapel Hill, back in 1955 when group psychotherapy sessions for wives of alcoholics were set up and headed by Dr. and Coordinator of Alcoholism Treatment and Research at N. C. Memorial Hospital, John A. Ewing of the Department of Psychiatry. The principal psychiatrists who conducted the sessions and made follow-up studies of the revealing character of the group were Dr. Ewing and working under him, Dr. Donald Macdonald. Both psychiatrists have made a written analysis of the sessions, which seem to point up conclusively that the wife of the alcoholic is closely tied in with her husband's drinking behavior and may severely affect his recovery or his continuing alcoholism.

The sessions were begun when it became obvious that the progress an alcoholic patient made was oftentimes dependent upon his wife's attitude and understanding. More and more it is becoming accepted by specialists working in the field of alcoholism that the wife of an alcoholic may consciously or unconsciously delay her husband's recovery. Many times she herself is as neurotic as her husband, although her symptoms may not be manifested in the same way.

For example, the wife may unconsciously enjoy her role as the martyred wife of a drunk so much that when this satisfaction is taken away from her, she becomes ill herself. In another case, the wife may encourage her alcoholic husband's dependency upon her by never giving him an opportunity to show his

manhood or make any family decisions. When suddenly he appears *sans* bottle and exerting a little authority around the house, she is thrown for a loop and cannot cope with this new personality. Unconsciously she wants a child-husband, although she will protest this loudly when confronted with it.

Alcoholics Anonymous has recognized this need for family education and rehabilitation through Al-Anon, which is available to wives, husbands and parents of alcoholics. However, Al-Anon meetings are much more informal and less psychiatrically-oriented than are group psychotherapy sessions.

Group Sessions

The group sessions at the University of North Carolina were set up on a 12-month basis, each meeting lasting 1 and ½ hours. The meetings were voluntary, the only requirement being that the husband be receiving treatment also. Weekly attendance fluctuated from a maximum of 9 on one occasion to 1 or 2 members frequently and to zero on at least one occasion. The usual attendance was 3 or 4 members, but as the group meetings became more widely accepted by the patients, the attendance grew to 16 wives out of 32 patients. The average age of the wives attending the sessions was 40 years.

In a report which appeared in the March, 1958, issue of the *Quarterly Journal of Studies on Alcohol,* Dr. Macdonald writes of his experience with the group.

It was decided that the group would meet once a week during the week-day afternoon, concurrently with the already functioning alcoholics' group. Thus husbands and wives would not need to make separate trips to the clinic. The group was "open" in that new members could join at any time. The sessions last 1½ hours, as it had been found from experience that this was long enough for a group to become "warmed up."

Prospective members were interviewed individually whenever possible in order to estimate their degree of motivation and explain the group program. Although this was in a sense a screening process, in fact no applicant was rejected as unsuitable for the group on the basis of the preliminary interview. In the course of this interview it was explained that the purpose of the group meetings was to help individual members deal with the problem of alcoholism within their families, and to understand more about themselves in the process. Thus only by inference were the sessions presented as a treatment program, in contrast to the alcoholics' group which had been set up explicitly as a therapeutic one from the beginning.

The group meetings were conducted in the traditional manner of psychoanalytically oriented psychotherapy; that is to say, the group leader attempted as far as possible to maintain a neutral, permissive attitude, with minimal activity on his part, allowing the group members to follow their own lines of thought during the discussions. No set program of topics for consideration was presented.

The group comprised the following persons:

Mrs. M., taciturn, quiet-spoken mother of an alcoholic daughter, and widow of an alcoholic; participated little during the sessions and only in response to direct questions, but attended regularly.

Mrs. G., well-read, sophisticated wife of a businessman; tended to present herself in as favorable a light as possible; was the main spokesman for the antipsychiatry faction within the group; attended regularly.

Mrs. R., wife of a professional man; prone to much intellectualizing in spite of previous individual psychotherapy; in a group readily assumed the role of "social worker" or auxiliary therapist and became quite anxious when her own problems were discussed.

Mrs. F., trained nurse and wife of a storekeeper; markedly orally aggressive

and somewhat paranoid in her thinking; felt strongly that nothing could be done as long as her husband continued to drink; was herself a moderate drinker; left the group after eight sessions with the avowed intention of divorcing her husband.

Mrs. N., rigidly moralistic in her attitude towards alcoholism; hypomanic and overtalkative in the group; left after a few sessions.

Mrs. D., borderline paranoid psychotic; overtalkative and monopolized the group; often interrupted other members to bring discussion back to her own problems; although her husband was not currently drinking she emphasized her continuing difficulties, to the discomfiture of group members who pinned their hopes on their husbands' achieving sobriety; attended only six sessions.

Mrs. Y., well-read but psychologically naive; placed considerable reliance on popular inspirational type of literature; dropped out after 12 meetings.

In looking back on his experience with the group, all not untouched by many of their own personal problems, Dr. Macdonald found that motivation of the wives, that is, the reason for their being there, was affecting the group as a whole. He found that each woman tended to monopolize the group by telling how martyred she was, how terrible her husband's drinking was or had been. Some felt that "nothing could be done", others were defensive, had a

TIME QUOTES DR. EWING

From Time Magazine, May 11, 1959

ALTHOUGH the wives of heavy drinkers usually complain bitterly about their husbands' behavior, liquor can be the the cement that holds the union together. Many a spouse of a souse, the University of Pittsburgh's Dr. William Browne told the APA, has an unconscious need for an alcoholically incompetent mate, because only thus can she be dominant. Curing a husband of alcoholism, Dr. Browne said, may make the wife ill, even drive her to drink.

In every such case studied at two Pittsburgh clinics, the wife knew of her husband's drinking problem before marriage. ("Marriage to an alcoholic is no accident," echoed the University of North Carolina's Dr. John A. Ewing. "Some women repeat it two or three times.") Dr. Brown cited one woman of 27 who had been beaten as a child by her father, kicked out of the house at 14 by her mother, married at 20 to a drunk. She could take these buffetings, but when her husband was cured of his addiction, she deliberately provoked arguments to start his drinking again.

Another woman, 30 rarely drank herself, but when her dipsomaniac husband sobered up after periodic week-long binges, she became so upset that she went on eating jags, gained 10 lbs. in two weeks. "I'd rather he drank," said she simply.

In a third case, both man and wife were recurrent alcholics, but always out of step: when he drank, she swore off; when he gave it up, she tippled—each partner getting a vicarious satisfaction and feeling of superiority from the other's drinking to the point of incapacity. "Alcoholism tends to preserve such marriages," said Dr. Browne. His prescription: psychiatric treatment for both partners.

Dr. Ewing agreed. Simultaneous treatment of husbands and wives at Chapel Hill has brought better results than tackling the husbands alone. But nearly all the wives have shown resistance because of unconscious motives; some have become so ill as to need hospitalization and others have openly sabotaged their doctors' efforts to dry out their husbands.

"chip on the shoulder". One woman, a wife who obviously wanted her husband to return to excessive drinking, "accidentally" poured whiskey into her husband's tea at a party. In all, Dr. Macdonald found that the women attending the group meetings had remarkably little insight into their own behavior and needs.

Other Factors

Other factors which affected the progress made by the group were the indiscriminate giving of advice to a particular person when her problem was being discussed and the hostility toward the therapist when he failed to give his own opinions or advice. They seemed to have wanted to be told what to do, rather than finding their own solutions, with the help of the therapist. In totaling the results of the sessions, Dr. Macdonald arrives at the conclusion that the meetings should have been more firmly structured with perhaps a showing of a film on alcoholism or emotional development at the beginning of the session and that more active participation on the part of the therapist would have been helpful. He felt that "psychiatric silences" were disturbing to the group.

Ewing's Report

In writing his report of the sessions, Dr. Ewing reveals that either total sobriety or very considerable improvement regarding drinking and marital harmony were obtained when the wives were receiving help along with their husbands. "We have accomplished considerably more with those alcoholics whose wives have been involved in group therapy. We suspect that acting out problems are at least as frequent, and probably more so, in the case of the wife who is not receiving any support or any therapeutic approach herself."

According to Dr. Ewing, certain specific trends tended to appear early in the wives' group. Some wives said they were attending only because it was the only way they could make their husbands come. Another said, however, that she was coming for her own sake, not for her husband's. A typical attitude towards drinking was expressed by many of the wives, "Drinking is not a problem—it's just a bad habit." One wife said openly that she was attending the sessions only so long as her husband remained sober.

Domineering Wife

There was much discussion among the wives about the "weak husband", yet they became angry when the subject got around to the domineering wife. The wife of the "weak husband" saw herself as a maligned, if not martyred, figure. It was often difficult for her to realize her own dependency needs.

Mrs. B. was one of the first women to admit openly that her husband's sobriety was causing her difficulty. Mrs. W. said, "I'm getting the silent treatment—it's worse than when he's drinking."

It was difficult for the wives to accept the fact that they were not making much progress in therapy, when compared with their husbands, but consoled themselves with, "We really have a harder task than our husbands—they have a focal problem of alcoholism to talk about. We have no such focus."

Dr. Ewing made a most interesting and enlightening discovery when it became apparent that although the wives expected total abstinence from their husbands, it was often impossible for them to give up their drinking for very long at a time. Six out of the 16 attending his group

wanted to continue drinking, although the psychiatrist found no instance where the wife herself developed alcoholism.

Like Macdonald, Dr. Ewing also found many of the wives were severely disturbed when their spouses quit drinking, showing real progress in therapy.

When the husband, by his sobriety, revealed a degree of strength and yet, by his insight, was learning to accept his dependent needs and to be less afraid of them, the wife was under pressure. She could sabotage his sobriety sometimes, or she could accept her own dependent needs, or she could find new substitute gratifications. Several wives of our most successful patients began to do more and more for people and organizations, instead of for the now sober husband. Of course the adjusted alcoholic *is* able to express his dependent needs much more easily and with less guilt or anxiety. This is done in a more steady, on-going way unlike the periodic abject dependence expressed by his drinking behavior. Some of the wives "need to be needed" to this degree, we believe.

Mrs. B., having lost the job of looking after husband, became quite depressed and had to be admitted to the hospital. She then worried that he'd drink in her absence—and she was right. Home once again she returned to group therapy and so did Mr. B., but he went on drinking for a few weeks. Meanwhile Mrs. B. thought that her husband was afraid to quit drinking again lest she have another breakdown. One day she suddenly decided to leave him and stay with relatives in another state. "I fixed that," Mr. B. told his group. "Gave her a bad check."

In concluding his report, Dr. Ewing writes that often wives are only trying to reassure themselves when they protest a need for a sober husband. Often the husband's drinking may cover up the wife's sense of inadequacy or failure. If the spotlight is on her husband's transgressions, then she need not examine herself so closely or have others examine her. Dr. Ewing supports these conclusions with factors found within the group, (1) the wives' sabotaging attempts (2) other resistances on the part of the wives (3) reactions by the wives, such as depressions, etc. (4) wives who took up drinking themselves.

Like the alcoholic, the wife of the alcoholic has certain needs herself and these needs must be fulfilled. In therapy sessions, it does no good to strip her of her personality, examine it closely and then re-clothe her in the same old material. If her husband becomes sober, she must be given something in return for his sobriety. For years she has lived in fear of or perhaps her needs have been fed by her husband's bottle. Either way, it is often a severe shock to have her whipping boy suddenly removed. When she is left with only herself to face, it may be too much for her and she becomes ill.

But offer her insight, let her know that she also is important, that she can be a help or a hindrance to her husband's recovery, enable her to channel her own dependency needs in a worthwhile way and the wife of the alcoholic should aid substantially not only her husband's recovery, but her own marital and emotional difficulties. Often therapy helps to break down the wall between man and wife that is the result of years of alcoholism, feuding, and bickering.

As one wife put it after attending the therapy sessions, "Now I can dare to let him know how I feel."

When a spouse is able to stop trying to reform her husband, the chances are improved that he will do something about it himself.

—from *Understanding and Helping the Alcoholic* by Howard Clinebell

ALCOHOLISM:

A plea for a new look, based on current knowledge about man.

PROGRAM development in the field of alcoholism is a problem with which many people are wrestling and an area about which firm guidelines have not been evolved. If alcoholism is viewed from the standpoint of human ecology, namely, concern with the multiple factors directly and indirectly related to the health and welfare of man, then new insights and fruitful approaches become apparent.

At this point in time it is urgent and imperative to take a new look at alcoholism. On the other hand, there is mounting public awareness and interest, as evidenced by recent legislative action. On the other hand, knowledge and experience gained through the broad spectrum of research findings in the total mental health effort offer a potential for great progress.

The thinking underlying this new look at alcoholism is based on two premises:

1. Human behavior (both physiological and sociopsychological) is a result of the complex interplay of many factors.

2. The breakdown of normal adaptive mechanisms of coping with life has many avenues of discharge, one of which is through the use of alcohol, which may or may not become a problem.

The men and women who have been working on problems of alcoholism in government - sponsored programs, in research institutions, in hospitals and clinics have done much to make it a respectable field in which to work. They have guided programs which now offer some hope in the treatment and prevention of alcoholism. Their assumptions and conceptions, like mine, are the result of experience. Theirs comes from long years of work in the field, mine from other areas broadly conceived of as psychiatry, public health, and social aspects of medicine. The interplay of these two views will serve as the foundation upon which we together can strengthen and direct our attack on alcoholism.

Where, then, must our alcohol programs go? First, there should be no alcohol program without a broad medical and mental health program. Second, such a broad program must be concerned with the spectrum of needs embracing adequate personnel, training opportunities, broad-gauge research, and changes in the patterns of services now available.

To accomplish this, there need to be funds. (Oftentimes it is easier to obtain funds than other things.)

THE PUBLIC HEALTH APPROACH

BY LEONARD J. DUHL, M.D.

PSYCHIATRIST

PROFESSIONAL SERVICES BRANCH

NATIONAL INSTITUTE OF MENTAL HEALTH

Condensed from an address delivered at the Ninth Annual Meeting of the North American Assn. of Alcoholism Programs, 27 August, 1958

Consultation and guidance must be available in all communities, continually aimed at integrating on one level or another our programs that are concerned with the well-being of man.

Alcoholism programs should be tied closely with university centers. Its experts must come more and more from people soundly trained as physicians, neurophysiologists, psychologists and sociologists, to name but a few. They should not be experts in the specialty of alcoholism, who happen to have previous training in medicine, psychology or sociology. They need to be human ecologists in spirit, and then specialists—individuals who can always look at the specific in the light of the general. Alcoholism programs must also, either in actuality or in practice, be tied to all other community programs concerned with man. To have a one-pronged attack on this broad problem of man is to court disaster. As in the famous story of the dike—in a weak wall, plugging one hole is a stop gap; building a good wall is sound; but controlling the flood waters, in toto, is best.

Who should participate in this program? All health and welfare organizations—perhaps most specifically health, mental health, rehabilitation, welfare and education. In addition, housing and city planning agencies, the police, both its accident division and its day-by-day operations, and the many other government and private agencies concerned. Along with this official "tie in" a great deal can also be accomplished through daily contacts with individuals in these various agencies. Similarly, to gatherings and meetings must come new blood. For the abstract scientist, philosopher, lawyer, and economist can shake us from the established inertia in which we are all so easily trapped. New ideas are, in fact, our most important weapon.

It should be apparent that in any priority of jobs to be done, the development of new theoretical models for alcoholism is of primary importance. Action programs concerned with specific areas or very categorical research and executed without a comprehensive theoretical base may be wasteful and even misleading. It is for this reason that all groups concerned with the well-being of man, who at the same time either consider themselves scientists or are responsible for the administration of a scientific program, should allocate time, energy, and manpower

to the development of such theory. Within such a monistic ecological framework, a theory of alcoholism would be more productive. This theory must of necessity be all inclusive. It must deal not with a summation of multiple variables, each of which is to be studied separately, but rather with the interplay of variables, all active simultaneously, each having different and ever changing weights; a complex interlocking phenomenon. A method of studying total situations must be developed. Within such a theory it will then be possible to determine the role of alcohol.

Our responsibility in guiding programs, therefore, lies in the nourishment and encouragement of these ideas. Concern with ideas precedes, or at least parallels, the development of any individual project or activity. What follows is a list of high priority research areas—many are not new and have been mentioned by others. They reflect, however, my basic concerns.

1. *Total Pattern of Alcohol Usage*

Recognizing the various roles of alcohol in the cultures of the world, it is of primary concern for us to understand its usage. Though we have had a group of studies showing various aspects of the problem, it is important to get a more complete picture. Who drinks, when and why? What are the influences—social, psychological and environmental? Under what conditions? Are these substitutes—things we might call alcohol equivalents? What conditions are involved in turning man from "the use of alcohol to control his environment" to "being controlled by alcohol"? Broadly stated, these studies can provide the answers to the basic questions about the use and abuse of alcohol which must be answered if we are to move ahead.

2. *Ecology*

Since there is, in fact, interplay of many factors causing this problem of alcoholism, we must determine what are the most manipulable factors affecting the total whole. This is an accepted public-health concept. In controlling malaria, for example, when it was determined that mosquitoes were the transmitting agents, eradication of their breeding spots was undertaken. We do not know what the manipulable factors are in the disease of alcoholism or, in fact, in mental illness. This ignorance should not keep us from trying various approaches.

At a recent meeting called by the Public Health Service to discuss programming in alcoholism, many of the participants were particularly stimulated by the point of view and program of Richard Poston. Poston's concern is with developing a total community program to deal with *all* the problems revealed by community self-study. Therefore, a program in alcoholism would be intimately tied to a study of total community needs and the interrelationship of these needs. To do this requires a skilled community organizer such as Poston, and the cooperation of all persons involved in community problems. Though programs such as this have proved to be empirically correct, they can only serve the researcher as a source of leads to a better understanding of the "organized complexity" of our communities, and the role of alcohol within it. Much study is still required.

3. *Community Studies*

Intimately tied to the questions of alcohol usage and public health measures are questions that can be answered by what we may broadly call community studies. Such urgently needed studies run the gamut from epidemiological and sociocul-

tural research projects to operations research on community-based service programs. The concern with alcohol-usage patterns parallels concern with the various coping patterns of man. How does man in given cultures and situations deal with crises? To whom does he turn? Who are the caretakers in the community, both official and others, who give him solace or help? What are the roles of our various institutions—the schools, play and work situations, the bars and pubs, the convention halls and social clubs and professional organization? What are the value systems in various cultures? How high is the threshold before a family or a community becomes concerned about a problem (alcoholism as compared to others)? What are the pathways to help? How much does our professional help reinforce and perpetuate illness?

We need better incidence and prevalence studies. We need morbidity studies. We must evaluate every aspect of our current and newly developing programs. The list of needed information is endless, but it is important to remember that such studies as those mentioned are part of the broader study of social and community problems. Alcohol also is but part of that problem.

4. *Human Biology*

Here again, there are questions to ask. Some of these are basic questions. What, for instance, makes an individual turn to alcohol rather than some means of solving his problems? Is it biological? Does it rest in the enzyme systems or hormonal pathways? Why can some individuals use alcohol without ever becoming addicted? Is there some constitutional weakness in some people and not in others? Is it a difference in the way the body of one person handles the metabolism of alcohol? Is a tendency toward alcoholism gene-controlled?

5. *Evaluation of Old Programs and Institution of New Ones*

Every patient, the family of every patient, and political leaders clamor loudly for treatment facilities. Obviously alcoholics must be treated by every means available, while it is realized that this is not the answer to the problem of prevention. No mass disease has ever been adequately controlled by attempts to treat the individual affected. Yet clinical programs must be improved. What directions should the treatment program take? Should better treatment facilities be provided for the alcoholic in the general hospital, should the attempt be made to interest more physicians and ancillary personnel in these sick people, should general clinics and mental health clinics be utilized in treating them? Will the newer drugs be more helpful in clinical management?

There have been many new program ideas worth trying. Some cities have been experimenting with a psychiatric team which is on call to handle emergency mental health situations outside the hospital setting. This type of service has proved effective in some European countries. It is a new approach and its possibilities should be more fully explored. What also should we do to provide follow-up and long-term supportive care for these patients? What should go into a rehabilitation program? Undoubtedly, many of these questions have been considered, and depending on the decisions reached an attempt has been made to direct programs accordingly.

Underlying all these questions about care and treatment services are the basic questions about their successfulness. Are these programs effective? Can methods be more

carefully evaluated? Do we really know the cause of apparently improved statistics, or are our methods inaccurate, incomplete and misleading? They are certainly not thorough at this time.

6. *Nomenclature*

In any program, language difficulties must be solved in order to be able to develop a body of knowledge that is universally useful. The field of alcoholism is no exception. The problem can be divided into two parts:

A. Development of professional nomenclature useful to the various disciplines active in the field.

B. Terminology useful in communicating with the lay public.

A professional nomenclature must serve several purposes:

A. It must fit in with the long established and widely used system of medical reporting, the American Medical Association "Standard Nomenclature of Diseases". Not to do so would make it unusable by a large and important group.

B. It must not confuse the biological with sociopsychological evaluations or with prognosis.

C. It should be in a form usable by those who need a nomenclature for either research or service.

D. Service-wise, it should be adaptable to statistical reporting by a variety of clinics, hospitals and agencies.

7. *Communication and Mental Health Education*

Transfer of knowledge and change in attitudes are basic to progress in any field. To date, health education, especially in mental health and alcoholism, has been poor. The recent study on the communication of mental health concepts at the University of Illinois suggests several things for us to consider.

A. There is a real gap in public information about mental health (including alcohol problems).

B. This gap is not filled by the mass media which are often behind the public in the correctness of their information.

C. To fill this gap requires a clear language understandable by the public.

D. Entertainment often transmits values, concepts and information better than the more strictly educational programs.

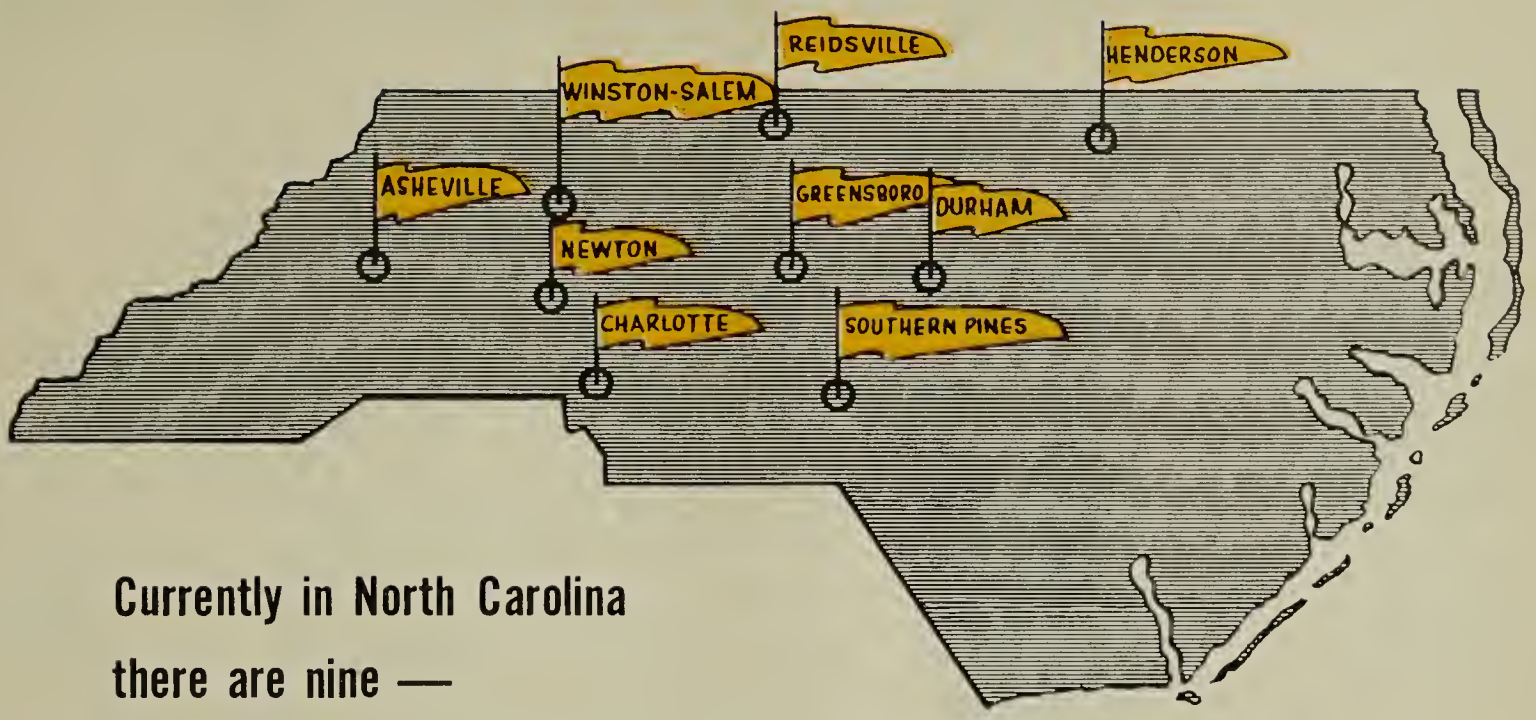
8. *Operation Research*

In earlier comments on research needs, those of the administrator and legislator were indicated. Often the results of research are not presented in such a manner that they can be used by an administrator. It is important that scientists present their data in such a form that it can be used to answer both kinds of questions; the basic and those related to decisions and operations.

9. *A Review of the Field Today*

There is need for continuous review of the information now available relevant to alcoholism. The National Academy of Sciences has begun such a review. This review should be analytic and critical, offering a careful re-examination of the scientific and unscientific assumptions and data upon which our research and programs have been based.

My plea is that we take a new look at alcoholism in the light of what we are learning about man and his environment. This new look demands coming out of isolation, and leaning on the theories, the ideas and the men from the broader world of science. It requires evaluation of what we have accepted, what we are doing and what we plan to do. If we are to be successful, we must be courageous, dedicated, and imaginative.



Currently in North Carolina there are nine —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—

Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)

Educational Division, Board of Alcohol Control
West Wing, Parkway Office Building, Asheville
Margery J. Lord, M.D., Administrator
William J. McCord, Educational Director

CHARLOTTE—

Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellerman, Director
William Hales, Associate Director

DURHAM—

Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Executive Secretary

GREENSBORO—

Educational Division, Alcoholic Board of Control
Greensboro
Mr. Worth Williams, Executive Secretary

Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Mr. Worth Williams, Executive Director

HENDERSON—

Vance County Program on Alcoholism
Reverend Edward Laffman
Route 2, P. O. Box 88A, Henderson

NEWTON—

Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton

REIDSVILLE—

Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SOUTHERN PINES—

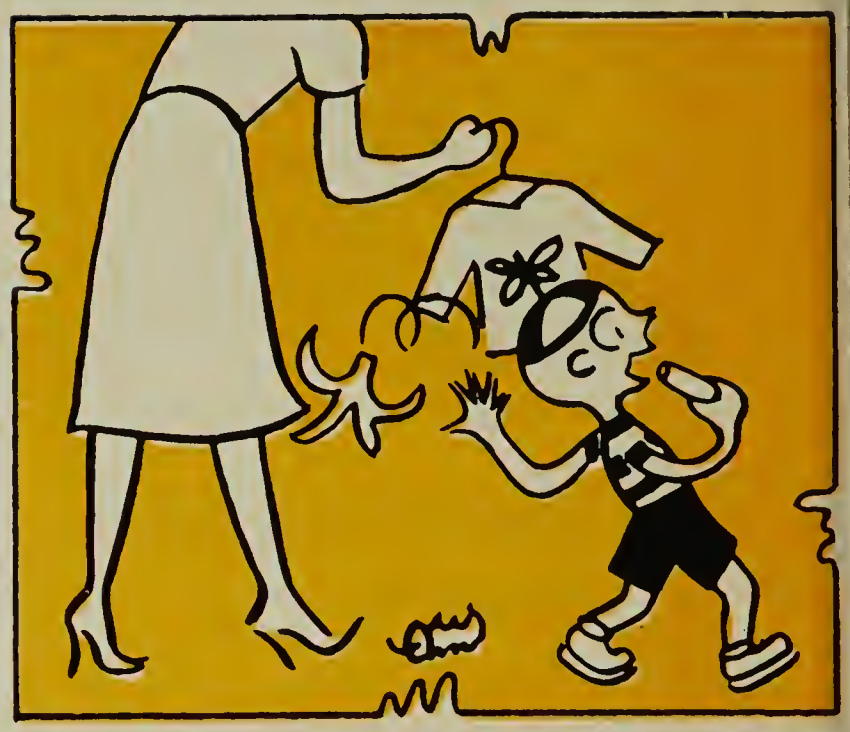
Moore County Alcoholic Education Committee
Rev. Martin Caldwell, Director
P. O. Box 1098, 350 S. Ridge St.
Southern Pines

WINSTON-SALEM—

Forsyth County Program on Alcoholism
Woodland and Seventh Streets, Winston-Salem
Mrs. Virginia O'Connell, Coordinator

"Alcoholics ar

1. Just continue to give him everything he wants. In this way he will grow up to believe that everybody should cater to his selfish whims.



3. Never make him responsible for anything. Just continue to pick up after him. In this way he will become adept in throwing all responsibility on others and when he reaches manhood, he will expect everybody else to do his work for him.

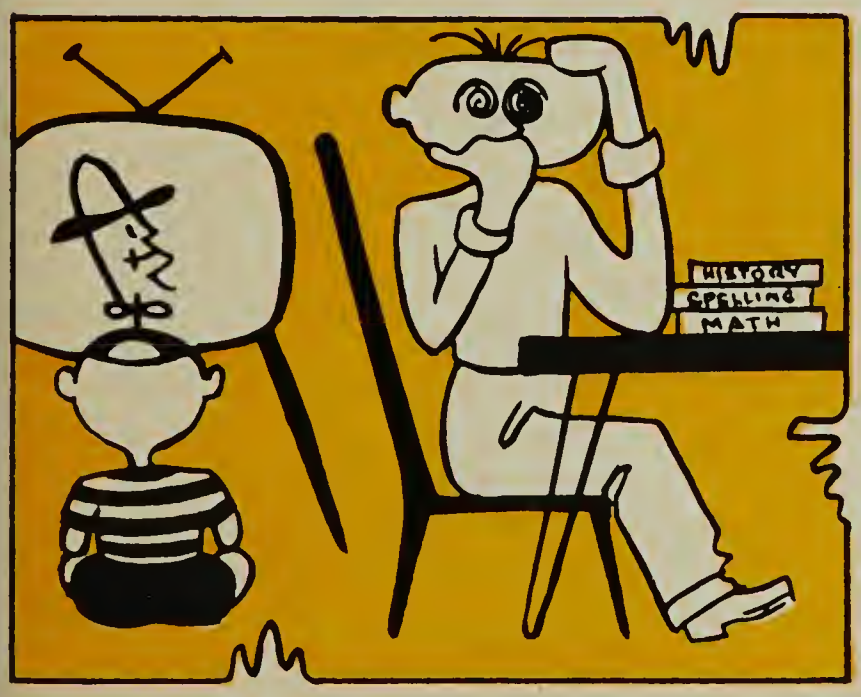
2. Never give him any spiritual training. Wait until he's "on his own and then he can decide for himself." Never teach him anything about God so that he will surely have no Rock of Ages on which to anchor his life.

4. Never correct him, lest you develop in him this thing called "guilt complex." Spare the rod and you will nurture a horrible rascal.

Do these things, ye smothering par
have a typi

Home-Made"

5. Smother him with love. Never turn him loose so that he learns gradually to be on his own. When he complains about the teachers or the "kids", you just join in with him condemning everyone so that he will have good training for that later-in-life complaint of the typical alcoholic: "Nobody loves me."



6. Never guide him to solve his own problems, so that he will certainly never learn that life contains a goodly portion of difficulties. Thus when problems do arise for him when he is out on his own he will most certainly seek refuge from them in a bottle.

7. And there's another thing that will help him become an alcoholic or perhaps emotionally ill in some way: when he plays in a game, always expect him to win and if the ball game doesn't suit Junior, tell him to pick up his ball and bat, break up the game and go home. He's sure to remain a poor sport the rest of his life, and he will never take defeat graciously.

8. Therefore, encourage his tantrums, and he will forever feel that he should always have his own way.

Text by Rev. R. P. Seiving, Newton, N. C.

nts, and ye shall
al alcoholic offspring. . . Amen

THE THERAPEUTIC COMMUNITY

BY R. MARGARET CORK

Reprinted from "Alcoholism," a publication of the Alcoholism Research Foundation of Ontario

FEWER than one in ten out of the 60,000-70,000 persons in Ontario suffering from the illness known as alcoholism are taking advantage of medical treatment facilities or of the program of Alcoholics Anonymous. Is this because there are too few clinics and AA groups? Or because other helping professions may tend to leave the job to so-called specialists in the field? Have such specialists, by encouraging referrals, unwittingly discouraged others from giving effective and needed help to many alcoholics?

My own belief, based on seven years doing treatment work at Brookside Clinic and considerable association with the work of AA is that the answer lies in developing a more "therapeutic community." By this is meant a climate of understanding and acceptance which can make rehabilitation and prevention also, much more real. Though there may be much room for improvement or growth in both clinics and AA groups, these alone are not likely to catch up with the growth of the problem. Instead there is needed a community approach to alcoholism so that people with real or potential drinking problems may become able to seek professional advice and guidance without too great fear or shame; so that those already ill may be able to seek help before the illness has too seriously affected their total personality or life situation.

This calls for increased concern and acceptance of responsibility by all members of all the human service professions. In turn, these professions can influence the large lay community. If the different professional groups in a community could deepen their understanding and work together as never before, we might begin, not only to rehabilitate a greater number of those already ill, but hopefully to discover more effective means of prevention. This calls for more than just greater knowledge about alcoholism and the alcoholic, more than just a problem of professional skills and resources. Over and beyond these it calls for greater understanding of past failures to rehabilitate the alcoholic, and greater acceptance of the need for all members of such service professions as physicians, clergymen, nurses and social workers to work together as a community team.

Ability To Give

Implicit in any effort to help the alcoholic is the ability to give of self, warmly and without expectation of much in return, as one does to small children; to give without needing to control or to possess; to be able to show a sense of caring no matter what the recipient's behavior, though not necessarily to condone the behavior. There are, however, two or three factors which often inhibit us from doing just this. I refer first of all to our own feelings towards drinking and drunkenness or the use of alcohol in any form. Most of us have remnants of misconceptions, prejudices and attitudes taken on from our parents, friends, or experiences, religious or otherwise. The point is not that we won't have these, but that we recognize them and learn to control them; to work our own way through our fears and conflicts as far as possible, for such feelings can seriously interfere with our attempts to help the alcoholic.

Next in importance is our ability to accept the degree of emotional immaturity seen in most alcoholics either as a result of regression from a previously achieved maturity or of arrested emotional growth. So many of the so-called adults we are trying to help may have the dependency characteristics of the infant, the small child, or the teen-ager (though

often hidden by considerable overt independence.) Unless we are reasonably secure in our degree of emotional and professional maturity, we may become threatened, and as a result may react to the alcoholic as indulgent, withholding, controlling, or directing parent figures. We may become conflicted by his inconsistency, his impulsiveness, and his low frustration level. We may become impatient with his inability to do what we know he is mentally capable of doing, or lose sight of his need to be given responsibility slowly. Often we may unconsciously meet our own needs in his dependency, or we may deeply resent his dependency. If we are not aware of the many implications of his dependency, we will be limited in our efforts to help him.

Limiting Factors

Other factors that limit us in working with alcoholics are: our inability to take the degree of hostility he shows, without hitting back or withdrawing in fear; our inability to resist being manipulated into a particular role, such as the "saver of the marriage" or the "protector of the job"; our inability not to get caught up in the alcoholic's sense of urgency, his impatience, so that we go faster than we know he can go; our inability to avoid taking on the discouragement and the hopelessness that is often inherent in the sick person, so that we stop trying to help; and last, but not least, our inability to know our own professional limits. The alcoholic, more than almost anyone else, seems to make us feel we can be all things to all people.

So much for some of the difficulties in helping alcoholics. What then of the business of working with our professional people? It will take a conscious effort on the part of all service professions to stop feeling threatened by one another; to gain a real appreciation of the particular contribution of others; to accept a degree of overlapping in each of our roles; to lose some of our possessiveness and competition to cure the alcoholic; and lastly to free him to relate to each of us, without allowing him to play one against the other. This calls for a conscious effort by each professional to get to know a person in each of the other helping professions in his community. This means getting to know not just an agency or a name but an individual and to know him personally, so that the alcoholic senses our trust and confidence in the person to whom we are referring them. We must not only learn to refer with genuine appreciation and acceptance of the service a particular person can render, but also to do without giving the alcoholic a sense of rejection. Go with him literally, or figuratively, as he seeks out a new source of help. Never confer about him or refer without his permission. Last, but not least, stand by and support him in his efforts to understand and use a new helping relationship.

Professional Roles

Having looked at some of the factors involved in the past failures to help the alcoholic, and at more effective ways of various service professions working together, I would like to touch more specifically on the particular roles I feel each key service profession might play in this whole problem. While the four professions which I have selected, general physicians, clergy, social workers and nurses, may each have a particular role to play, I would suggest that much of what I have to say should have meaning also for teachers, probation officers, personnel workers and all who may be in

contact with these troubled people.

I would focus on the general physician first, not because the alcoholic is primarily a physicially damaged or physically ill person, but because the physician in general practice is one of the most likely to see the earliest manifestations of what may eventually develop into the most psychiatric disturbances, and he will have the best opportunity of preventing them if he is properly prepared (oriented and sympathetic) for the recognition of the early danger signals. Long before the alcoholic or his family recognizes the deeper, more serious aspects of his illness, he may seek help from a physician during or following a drinking bout. While many physicians have, since the problem began, successfully treated hundreds of alcoholics, the fact remains that too many are still fearful of or for other reasons are unable to treat the illness successfully in its early stages. Too many are still treating the symptoms only, and the prescription is a palliative which may switch an alcoholic from drink to drugs. Often the prescription given for on-going treatment is in such words as "Cut out the stuff" with no direction or help in taking the prescription. Rarely is such a prescription taken seriously for any length of time by the patient, even when there is a real threat to life through serious liver damage, ulcers or other physical complications.

The Clergy

Let us turn to a second helping profession—the Clergy. Often the pastor or priest is the last person in the church to know that a parishioner has a drinking problem. The shock and the concern he may feel on hearing about it often gets in the way of his truly helping the alcoholic. Many of his traditional ways of helping people do not work. Traditionally the clergy have seen alcoholism solely as a moral problem and attempted to help the alcoholic by pointing out the wrongness of his behavior, thus adding to the great burden of guilt he already carried within him.

Today there is a growing awareness of the clergyman's role in rehabilitation and education in the field of alcoholism. Along with this is a recognition on the part of the clergy of their need to bring to their role a new understanding and a new or different use of their traditional skills.

Immaturity

The challenge to the clergy as it seems to me, is not just to learn more about alcoholism but to see the alcoholic as a person whose approach to an understanding or acceptance of God's love is immature, in spite of early attendance at Sunday school or church; whose guilt and fears, in relation to clergy in particular, are so great that it takes tremendous courage to approach the priest or pastor for help. The alcoholic however comes to his clergyman not just because he wants help with his drinking problem, but often because he wants, like most of us do, to be a better person or to find a new meaning to life.

A third professional service group are the nurses, particularly public health nurses, who have perhaps one of the greatest opportunities to be in contact with the alcoholic and/or his family. Public health nurses have access to all homes where there are school-aged children, and thus have a greater chance than most of the other helping professions to know of upset children and disturbed family life due to alcoholism. More often than not the nurse is reluctant to use this opportunity to recognize the illness or

to act effectively in getting the alcoholic to treatment. Very often the nurse may give intense counselling to the wife of the alcoholic on all other health problems but fears to counsel "for the sake of peace", or because she is "fearful of interfering" on the major illness in the home.

Not only public health nurses but nurses in medical wards with alcoholic patients admitted with a diagnosis of a liver condition, nurses on psychiatric wards, and nurses on emergency—all have a rare but real opportunity to relate to the sick person at a time when his defenses may be down, when he is feeling contrite or humble. Perhaps for the first time in his life he might be given some of the tender nurturing we all need, especially when ill, and through the nurses' interest and acceptance of him as a person, begin to gain some security to talk about his problem or contemplate doing something about it.

The fourth and last professional group I would like to discuss are the social workers, chiefly those in social agencies serving families, young people and children. Traditionally social workers, like other helping professions, have attempted, without any greater success as a group, to help the alcoholic. Like most of the other professional groups, the social worker has become discouraged, frustrated, and has often taken on a feeling of hopelessness because of past failures. Social workers however, by training should be the best equipped to help the alcoholic use formal treatment services and to work directly on the realistic problems which he has, both as cause and effect of his drinking. They can give leadership in the community as they work in a cross section of it, not only toward better understanding of the alcoholic, but also in their work of stabilizing family living toward the concept of prevention.

These then are four of the professional groups who I feel have a significant and actual role to play in treatment and prevention in this field of alcoholism, not just as individuals with particular skills, but especially as members of a community team, sharing and pooling skills and responsibility. Such a team should not only be able to share appropriately and realistically in rehabilitating the alcoholic but each member must assume a responsibility for interpreting the illness and the ill person to others in the community.

Professional people have been slow to use their known and tested skills in the field of alcoholism. In spite of the advances made in the last fifteen years or so in studies of this illness, it is increasing at a greater rate than most of us realize. Well-established clinics and AA groups working at full speed cannot begin to cope with those already ill. I do not say that community teams per se are the solution to the problems presented by this illness. I do believe, however, that through such an approach larger segments of our communities might more readily change their attitudes and more quickly lose their fears; that within an atmosphere of community acceptance, thousands of alcoholics not yet getting help might find the courage to acknowledge their illness; that above all, the helping professions might begin to lose some of their individual sense of apathy, discouragement and isolation, might individually revitalize and revamp their time-tried treatment skills, and together with other helping professions find the answers without which we cannot combat one of the most serious illnesses of our time.

"You don't know what it is all about! You don't understand!"

That cry, properly interpreted, tells several reasons why the abnormal drinker is often so hard to help. Properly interpreted, it goes far to explain the drinker's antagonistic attitude toward those who plead to be allowed to help him. Usually he does not welcome the offer of help; instead he is irritated and offended.

It seems to the alcoholic that others ridiculously magnify the importance of his drinking problem. Meanwhile his illness blinds him to the true proportions of his predicament. In all likelihood his mind does not focus properly on any of his affairs, either those directly related to his drinking or those totally remote.

At the moment let us assume that the alcoholic we are discussing has not yet reached the realization that he is personally helpless against his problem. And let us assume that he is at the stage wherein his drinking has become dangerous to himself and all those around him—yet he will not admit the gravity of the situation.

We already know some reasons why the abnormal drinker recoils

by

THOMAS FULLAM

We can lead a man to sobriety—for a while; but we can't make him abstain. Not if he has the freedom to drink.

from admitting the reality of his problem; one of these is the moral issue. Any of us, I presume, would be loath to go to others with an admission of so-called moral infirmity and ask help with it, but to worsen the matter, others may come to the alcoholic to tell him of his infirmities and thus fire his indignation at being selected as the neighborhood leper. The presumptuous outsider bringing such an incriminating and degrading message is seldom received with thanks.

Perhaps the non-alcoholic reader may think I am piling it on pretty thick in my use of the term "moral leper." I assure you that the alcoholic suspects that he is regarded by others as just that.

There is something terribly humiliating in having others come to us with good wishes and good advice and offers of help for our pathetic yet abominable weakness. None of us can be happy in the thought that others consider us weak; and, while we have no power to prevent others from thinking so, our humiliation is pyramided when we are asked to admit it.

It is this superior approach to the alcoholic that is wrong although it may be rooted in the best wishes and anxious concern for the welfare of the problem drinker. But the result is to bring about resentment, antagonism and an unwillingness to cooperate.

Imagine the tubercular patient being viewed by sadfaced friends who expound at length about right and wrong and the necessity of the patient mending his ways! The net result of such a call would be a severe set-back for the patient. Setbacks so often eventuate from the efforts of friends to make the abnormal drinker see the error of his ways that even good friends at last throw up their hands and decide that if he doesn't want to be helped—well, then a bad end to him!

The drinker's outward reaction to these vain efforts of others will vary with his physical and mental condition at the time. If he is very sick physically, his morale extremely low, he is apt to listen quietly as though he were seriously considering the proffered advice. Usually he is not listening gratefully or receptively in these instances. It is probable that he is marshalling his strength, privately resolving to retaliate when he is stronger. He may be so ill at the moment as to postpone an outbreak of his anger. Anger calls for energy which he doesn't have to spare.

Possible Reactions

If he is in fair condition he may suggest that the other mind his own business or he may grow abusive; or he may merely shrug his shoulders and offer some vague excuse for his drinking. If he does privately recognize that he has a serious problem he is also aware that it is *he* who is going through the experience—not someone else. And if *he* cannot see through the enigma then how can this someone else?

In most cases the advice of others is entirely wasted. If the alcoholic refuses to discuss his problem frankly he will likely say or imply, "What's the use of discussing it with you? You don't understand."

Is his attitude entirely unjustified? I don't think it is and for reasons I will give.

The problem drinker is well aware that many who try to help are not capable of helping because they truly do not understand his problem. Few of us would be content to call in the city's best auto mechanic in case of sickness in the family. The mechanic might be an intelligent fellow, adept in his trade; but

any of us would realize that an appendix is not in the auto mechanic's line.

We call an electrician if we have something wrong with the lights or power appliances. We call the plumber, not the doctor or electrician, if the pipes are leaking or the lavatory stopped up. And when we call the plumber we are quickly aware that something is wrong if he stands around bewildered. If he can't take prompt effective steps to search out the trouble and correct it efficiently we soon reach the conclusion that we have the wrong man on the job. Any of us would sense that sort of inadequacy in a hurry.

The sick alcoholic in his jitters-bed doesn't need to be supremely alert to recognize that others who are trying to help him are just as bewildered as he. He doesn't see them reach expertly to the heart of his problem and make an adroit adjustment. He sees these people, like novice plumbers, groping and grasping for clues and guessing at what to do.

Seeing this, is it any wonder that he may say, "You don't know what it is all about. You don't understand."

And it is generally true.

There is little point in denying that few people have been capable of help of any value, few people have known just what kind of problem they were up against. And this is not to disparage those who have sincerely tried to help. All of us have had friends who would have done anything possible for us had they known what to do. They did their best in accordance with their lights.

But there is another exasperating aspect of attempting to help the abnormal drinker and that is his stubborness in resisting even competent help.

Has Faults, Too

I do not suggest that the alcoholic is an innocent cherub caught in a malevolent whirlpool of circumstances which have singled him out to be a suffering and saint-like martyr. The alcoholic is human and, like all humans, has his faults in abundance.

One of these faults is false pride; another is a stubborn unwillingness at times to share his recovery with someone else. This unwillingness may stem from his inner convictions that his problem may be one of moral turpitude, a hangover from the teachings given him or the sermons he has heard given to others who had the problem before him. At least he understands that public opinion is not on his side and he wishes to avoid condemnation as much as possible.

Sometime ago, at the request of friends, I called upon a man who definitely had an alcoholic problem, and a bad one. My suggestion of help through Alcoholics Anonymous was rejected by him without thanks. Though he was willing to admit he had a serious problem, he flatly declined help since as he informed me,

"Any man who is any kind of a man at all can do it by himself."

Clearly, he had been bitten by the moral-issue and you-are-a-weakling doctrine. He resented the theory that his trouble was due to a lack of manhood. He wanted to disprove the allegation but if he were to accept help this would be, in his eyes, an admission of the charges. Since then this man has quit drinking entirely —the hard way.

I attempted to persuade him that his problem was not one of morality or weakness of character but it was a vain attempt. He was barely able to speak at the time due to laryngitis and I commented on this. He told me of a medication he was using, one he had obtained from his doctor.

"Why," I asked, "are you willing to accept help from others for a sore throat when you are not willing to accept help for a more serious ailment?"

In a low husky whisper he managed to reply, "That's different."

I could guess how it was "different." No one had ever sold him the idea that laryngitis had anything to do with moral depravity. Consequently it was not embarrassing to go to a doctor for help for his bad throat.

Make Everyone Miserable

This do-it-yourself school takes some inhuman beatings although now and then one of them does manage to succeed. But too often the do-it-yourself men exist so miserably through their years of galling sobriety that they make everyone around thoroughly miserable too.

The alcoholic's problem — he is prone to think — is something special; something he must correct himself although his chances of doing it are almost nil. And he deludes himself in his attempts at self repair for in the final analysis he rarely tries to quit drinking on an all-time basis. Instead he gropes for the old road back to controlled drinking; but the old road is gone. None has ever been able to find it again once it is lost.

This pet notion of the alcoholic that his case is "different" has a foundation of sincerity sometimes and sometimes it has not. There are times when he doesn't want his case to be understood. This mental evasion, I believe, is a defense against anyone who might make an effort to interrupt his drinking.

This defense prevails sometimes against the logic, experience and straightforward approach of other alcoholics who have recovered. If he were to admit at this point that his case was *not* different, he could not hope to be invulnerable against the logical appeal of the recovered alcoholic who does see through his predicament, his thinking, his "reasoning" and his excuses for continuing to drink.

It is at this point that our problem drinker may be considered hopeless by non-alcoholics and alcoholics alike. His "I am different; my case is unusual," is a blinder he volun-

tarily puts on so as not to be forced to see his problem in its true light. For him the appeal of liquor is still irresistible and he fears anything that may stand in the way of his drinking. He is still enamored of the bottle; still deriving enough pleasure—despite the bad aftermaths—that he cannot tolerate the thought of giving up his toy and crutch.

A crutch, as we usually think of it, is a physical support for the lame, not a pleasant thing to be forced to use. Alcohol has often been adverted to as the alcoholic's crutch—the implication being that he should be willing and glad to throw away his crutch at the earliest moment possible.

Crutch Also Toy

But this crutch analogy is not without fault. For the alcoholic's "crutch" is also a toy—a thing of pleasure as well as a means of support. Viewed in that light it is easier to see that the problem drinker does not want to give up something which supports him in difficult times and also gives him pleasure, a state of mind he finds comforting. There are too many arguments in favor of his continued drinking to expect that he should be willing to bid farewell to his liquid assistant simply because someone scornfully refers to it as a crutch, implying that he is a mental cripple of some kind.

But he doesn't miss the implication nor does he fail to resent it. He shrugs off the suggestion as nonchalantly as he can and tells himself, "They don't know what it is all about. They don't understand." And he may tell the psychiatrist, the doctor or the recovered alcoholic who attempts to help, "Oh, my case is different."

This seeming voluntary blindness is a maddening obstacle to those who try to help the abnormal drinker. Certainly, he does not realize the seriousness of his plight. He is hypnotized by the allurements of a drug which seems to offer something desirable and necessary for an endurable state of mind.

He will not stop drinking because he does not want to stop drinking, cannot want to stop and won't stop if he has access to liquor.

No man quits drinking until he *wants* to quit—barring confinement of course. We can lead a man to sobriety—for a while; but we can't make him abstain. Not if he has the freedom to drink.

When we view abnormal drinking as merely the *evidence* of a disease, it is much easier to see that expecting the problem drinker to renounce his symptoms is much like asking the man who suffers from hives to give up his desire to scratch himself. The victim of compulsive drinking has an intolerable mental "itching" and the only possible kind of "scratching" that will bring any relief is—drinking.

But alcoholism is that sort of disease; exasperating, frustrating. And like the panic stricken drowning

THE therapist who is unable to accept the pleasurable connotations of alcoholism will seldom be able to affect favorably those whom he should help. Lack of acceptance of this pleasurable connotation often leads the therapist to rejection of the alcoholic. This rejection is rationalized in a variety of ways, the most common of which is expressed in the statement, "The case is hopeless."

Giorgio Lolli, M.D.

man who resists the efforts of his rescuers, the alcoholic seems determined to resist— and pull down all those around him who try to help.

But our illnesses and our symptoms don't beg permission of us to take the forms they do. It seems that we must take them the way they come. Alcoholism won't heed our pleas that it run its course in a pleasant easy-to-handle way.

There are good reasons why some people can drink safely and some cannot. There are good reasons why some people can take a few drinks and stop while others may be forced to go on and on. These reasons have nothing to do with manhood or womanhood or morality, or, for that matter, intelligence. Understanding these reasons is the first and wonderfully important step towards sobriety for the alcoholic.

Perhaps the "psychological crisis" —emotional bottom—comes to the problem drinker when the hard shell of conceit and false pride which envelopes him is shattered by the impact of a realization that he is after all—an alcoholic, that he must give up drinking entirely or go all the way to the bottom—a bottom that he, for the first time, begins to discern.

10 SAFETY SIGNS for Good Mental Health

by

GEORGE S. STEVENSON, M.D.
Medical Consultant
National Association for Mental Health

A tolerant, easy-going attitude toward yourself as well as others.

A realistic estimate of your own abilities—neither underestimating or overestimating.

Self-respect.

Ability to take life's disappointments in stride.

Liking and trusting other people and expecting others to feel the same about you.

Feeling a part of a group and having a sense of responsibility to your neighbors and fellowmen.

Acceptance of your responsibilities and doing something about your problems as they arise.

Ability to give love and consider the interests of others.

Ability to plan ahead and setting of realistic goals for yourself.

Putting your best efforts into what you do and getting satisfaction out of it.

ON GIVING AND RECEIVING

BY ROBERTA LYTLE, M.S.Sc.

We have the responsibility as mature human beings to be able to give or take, as any given situation may demand.

Recently an AA friend of mine said to me "You know, it is hard to be at the receiving end". For her this had meant many things—during her years of uncontrolled drinking she had been at the receiving end of well-meant but ill-timed advice, of anger, of scoldings, of punishing behavior on the part of relatives and friends, of recrimination. She had also been at the receiving end of worried looks, of over-solicitude, of misdirected therapy, and of complete rejection. There had also been pity, kindness, even love; but to one already suffering from a deep and predominantly unconscious feeling of unworthiness as a person, this could do little but aggravate such negative feelings.

Even the kindest acts or intention accentuate such a person's awareness of her inadequacy to the point where guilt steps in and, using anger as a cover-up, separates her further from those who would love her and by whom she would prefer to be loved. This is complicated by the attitude of our modern society which reminds us in a thousand ways that we do not expect to receive without being able to exchange on an equal basis with the giver. We do not accept favors, for example, if we don't expect to return them; we "exchange" gifts at Christmas; we "repay" a visit or an invitation to a party; we speak of our "social obligations" with an air of knowing what is the "right" thing to do. This we consider part of our privilege of belonging to adult society, even though at times we might call it a bore.

This differs considerably from the prevailing pattern of social intercourse of the young child, particularly the infant, who can and should, expect unlimited giving according to his need—giving of attention, care, help, understanding, patience, acceptance, forgiveness—all the equation of love, so that his emotional and

spiritual growth may be nurtured sufficiently. Since he dwells in a world of feeling, where most of his experience of the goodness or badness of his world is interpreted through his senses—(milk tastes good because of the loving nearness of the mother who gives it—the teddy bear gives comfort in the night because a comforting father put it in the arms of the child as an extension of himself and his own protecting love). This given with no strings attached, freely and because the child needs it, leaves with its small recipient no sense of obligation, only a warm, comforting, reassurance that this is a good, safe place to be. It frees the child to grow, exploring new avenues of life, encountering new adventures, reaching out toward new relationships, unhampered by fear, uncertainty, or guilt. Because adequacy is expected from him only so far as his limitations will allow, his growth and enjoyment of life are recompenses enough to his parents —his very responsiveness to affection is ample return on their investment of love.

Give or Take

If we consider the implications of this kind of thinking, we come to the conclusion that if, as children, we have the right to expect unlimited giving according to our needs, then we also have the responsibility, as mature human beings, to be able to give or take, as any given situation might demand. We acknowledge that in maturity, neither giving nor taking need be at a price, but can be the means of expressing love for another, uncontaminated by guilt on the part of the receiver, because there is no demand for recompense on the part of the giver; that the roles of giver and receiver are interchangeable, according to the occasion.

The problem of my friend was that her ideas of giving and taking were all confused. She had reversed the time signals. An adult, physically and chronologically, she had been trying to live out, however unsuccessfully, through her uncontrolled drinking, a pattern of life which was no longer appropriate. She had wanted to assume the child's role, to capture in fantasy, if not in fact, that sense of wholeness, of worth, of belonging, which supplies the motivation for living. For her there was no built-in mechanism for its accomplishment—she needed something outside herself, some potency which she did not possess, and which for her would be the magic answer to her need. Some find it through other forms of illness—she found it through the illness of alcoholism.

Affects All Of Us

This dilemma of giving and receiving is not confined to the alcoholic alone—it affects all of us at one time or another. It is difficult for us to be aware, frequently, of what we actually have received, because it has not always been clearly evident to us—on the other hand, we might very well have been short-changed by those from whom we should have been allowed to expect more. If we arrive at a solution, and most of us are seeking, one, we may do so by various paths, but ultimately we must find that dependence through which, without obligation, though adult, and without evading reality, we can still become once more as "little children", a freely receiving that we may freely give, in full and responsible maturity. It takes a new outlook on life to feel and know that we have been given much. For most people this constitutes a religious experience. In A.A. they call it reaching out to a Higher Power —many call it reaching out to God.

Books of Interest

ONE DRINK AWAY

BY GORDON SEAY

Heritage House
Charlotte
123 p.p.

"I am today and I will always be, an alcoholic. I must never, under any circumstances, forget that fact. At any time that I allow myself to fall back into my old ways of thinking, I am skirting disaster. One thought I must keep foremost in mind—one drink of whiskey will inevitably plunge me back into a pit of darkness from which I may never have a second opportunity to escape. One drink will do the trick."

So writes Gordon Seay in his novel, "One Drink Away", in which he tells his personal history of years of drinking, disillusionment and frustration before he found sobriety through the help of his wife and Alcoholics Anonymous.

This book is not too different from many others which have been written by alcoholics about their alcoholism, and such books usually follow a pattern of telling how far they fell before they hit the bottom, how many pints or fifths they consumed daily and how many people they wronged while doing it. The interesting thing about "One Drink Away", however, is that the author can write. He tells his story, although it is one heard many times before, with insight and a good sense of the use of the English language.

"Somehow it seemed that a drink was the answer to everything. Whether I was celebrating, brooding, or repaying a favor, it was the same—a drink of whiskey. I crossed the borderline that separates casual drinking from alcoholism. The worry-drink-remorse cycle moved ever faster.

Desperate Search

"There is nothing more desperate than the alcoholic's search for a drink when the liquor within him is beginning to die. It is a discouraging thing to know that whiskey no longer brings a feeling of pleasure and well-being—especially when you know it is utterly impossible to do without it."

Gordon Seay had a hard time making his recovery. After 14 years of sobriety, he once again fell victim to his illness on the morning when his second child was born. That day began another nine years of drinking during which his job as hospital superintendent, his family life and his social life almost completely disintegrated. Then AA was introduced to him and once again Gordon Seay gave up the bottle, only this time he feels he can live without it permanently.

"I have been sober, now, for three years. Home has become a beehive of activity. Days just aren't long enough for the things that I must do to make up for twenty lost years. It is fun to be alive, for I feel that at last I am a whole man."

All who read his story will wish Gordon all the luck. *CC*

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the
Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program
On Alcoholism
7th & Woodland, Streets
WINSTON-SALEM , N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County
Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speaker—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Display—primarily for local public libaries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

SEPT.-OCT., 1959

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Tar Heels At Yale

The Nature Of Mental Health

Western Electric's Approach

Alcoholism As A Community Health Problem

Role Of The Elementary School In Alcohol Education

Barbiturates As Addicting Drugs

Letters To The Program

What's Brewing?

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, social worker, a recreation director, an occupational therapist, and ten attendants.

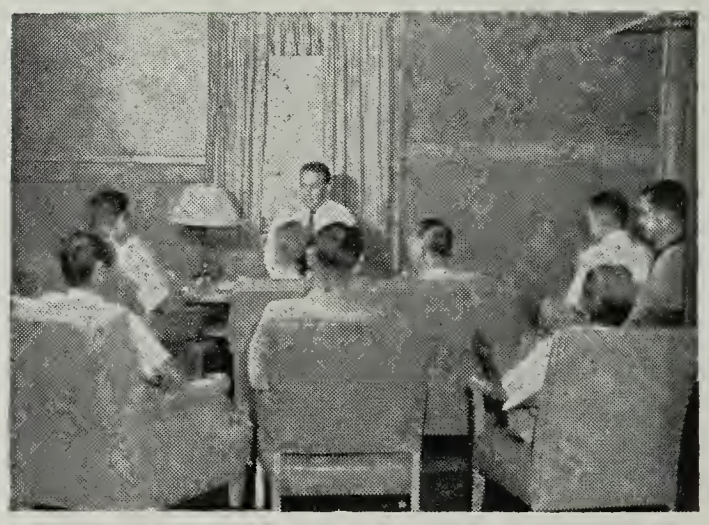
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday

Patients must be sober upon admission, and in good physicial condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

GEORGE H. ADAMS
Educational Director

DONALD MACDONALD, M.D.
Medical Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

INVENTORY

VOLUME IX NUMBER 3

SEPTEMBER-OCTOBER, 1959

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

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Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

WINSTON-SALEM: Mrs. Virginia O'Connell, veteran coordinator of the Forsyth County Program on Alcoholism has resigned. In her place the Mayor's Committee has appointed Mrs. Inez S. Wolfe, a trained social worker who for the past five years has been employed by the Wilkes County Department of Public Welfare. Congratulations and best wishes to Mrs. O'Connell for the outstanding job she has done. And a hearty "Welcome!" to Mrs. Wolfe as she assumes her new duties.

RALEIGH: Dr. Eugene Hargrove, Commissioner of Mental Health, has announced the appointment of Dr. Donald Macdonald as full-time Medical Director of the NCARP. Dr. Macdonald has already begun active direction of the Alcoholic Rehabilitation Center at Butner, and is planning improvements in the Center's program and services. The Raleigh staff is pleased to welcome Dr. Macdonald to the ARP family.

CHAPEL HILL: Drs. A. J. Atkins of the Alabama Polytechnic Institute and J. Minor Gwynn of the University of North Carolina have produced a new reference work for teachers entitled "Teaching Alcohol Education In The Schools." The book is directed mainly at teachers and school supervisory personnel interested in providing alcohol education in the public schools.

CHARLOTTE: The Charlotte Mental Health Clinic has recently published its annual report. This Clinic is the only one in the state which has a full-time Psychiatric Social Worker serving as Specialist in Alcoholism Problems. Mrs. Gladys Riddle has held this position for several years and spends a large portion of her time rendering services to alcoholic patients and their families. Mrs. Riddle, through her understanding and guidance, has been of inestimable service to many citizens of Mecklenburg and surrounding counties. Bouquets to Mrs. Riddle and to Dr. Marshall Fisher, Director of the Clinic, for their fine work.

CAPE COD, MASS.: The tenth annual meeting of the North American Association of Alcoholism Programs was held September 8-11 at the Belmont Hotel in West Harwick. Leaders in the field of alcoholism from all over the United States and Canada attended. Featured participants in this year's meeting included Dr. Jack Ewalt, Professor of Psychiatry, Harvard Medical School and Superintendent of the Massachusetts Mental Health Center; Dr. Erich Lindeman, Professor of Psychiatry, Harvard Medical School and Chief, Department of Psychiatry, Massachusetts General Hospital; and Dr. Joan K. Jackson, Research Instructor, Department of Psychiatry, University of Washington. Special workshops for social workers, physicians, educators and administrators were held in connection with the four day meeting.

RALEIGH: The Raleigh offices of the NCARP have been moved from the Old Health Building to 216 North Dawson Street. The Post Office Box Number, 9494, and the telephone number—TEmple 4-3611, Extensions 7351 and 7352—remain the same.

BUTNER, N. C.: ARP Medical Director Dr. Donald Macdonald announces a change in admission procedure at the Alcoholic Rehabilitation Center. Henceforth, all requests for admission should be directed to: Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C. In the past admission appointments have been obtained through the Superintendent of the John Umstead Hospital and patients have received their admission physical there. Effective immediately, patients will be admitted directly to the Alcoholic Rehabilitation Center.

CHAPEL HILL: On September 28 and 29, this University community hosted a conference of representatives from state and local alcoholism programs in North Carolina. All sessions were held at the Institute of Government. The conference was exploratory in nature, following a flexible agenda and allowing opportunity for discussion. Out of this and similar meetings projected for the future is expected to grow a better coordinated effort to treat and prevent alcoholism in the state.

QUEBEC, CANADA: A sixth Canadian province seems likely to establish an alcoholism program before long. Dr. Andre Boudreau has been appointed by the government of the Province of Quebec to lay the foundation for a commission to do work similar to that of official alcoholism programs in other provinces.

GOLDSBORO: Four NCARP staff members—Dr. Macdonald, Dr. Kelly, Miss Lytle and Mr. Adams—will participate in an institute for Episcopal Clergymen in the Diocese of East Carolina, to be held in Goldsboro on October 27. Invitation to conduct this meeting came to Dr. Kelly from Rt. Rev. Thomas H. Wright, Bishop of the Diocese, and Rev. Hunley Elebash, Rector of St. John's Episcopal Church in Wilmington.

Excellent Publication

Would you please re-route my copies of INVENTORY to the new address. I want also to commend you on the excellence of this publication. As a priest working frequently with alcoholic problems, I find the articles most helpful for giving advice in particular situations and cases.

Rev. Richard J. Weigler, S.J.
Portland, Maine

Valuable Aid

I want to thank you for sending me your excellent publication, INVENTORY. I have found it a valuable aid in our course in psychiatric nursing.

James A. Wallace, M.D.
The Wallace Hospital
Memphis, Tennessee

Minister Writes

I surely do appreciate receiving your magazine. I would prefer not missing any of the issues so please note my change of address.

Richard P. Fehnel
Assistant Minister
Millersville, Pa.

Helpful In Counselling

Please send me your publication, INVENTORY. I have read some copies of it, and I consider it to be a fine and useful report in the field of treating alcoholics. I am a counselor in the North Carolina Baptist Hospital, and I would be glad to receive any other materials on counselling alcoholics that you have available.

Daniel W. Fielder
Winston-Salem, N. C.

Enjoyed Article

Dear Miss Lytle:

I read your article in the July-August issue of INVENTORY and find it very interesting. I find it especially so because you emphasize so much the process of giving and taking which is something we do here at the School. Your understanding of the universality of this process seems so essentially sound.

Mrs. Isabelle K. Carter
Associate Professor
UNC School of Social Work
Chapel Hill, N. C.

Help Appreciated

Dear Dr. Kelly:

The Rev. Hunley Elebash has told me about your good letter to him and the plans being made for our Clergy meeting on October 27, with the idea in mind of developing a program on alcoholism for the Clergy of the Diocese of East Carolina.

This letter is to let you know how much I appreciate your willingness to help us with the above and I am, indeed, looking forward to being with you at the meeting in Goldsboro on the above date.

Rt. Rev. Thomas H. Wright, D.D.
Bishop, Diocese of East Carolina
Wilmington, N. C.

VOL. IX NO. 3 INVENTORY SEPTEMBER-OCTOBER, 1959

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Western Electric's

Approach To The Treatment Of Alcoholism

BY E. A. HOFFMAN

WESTERN ELECTRIC COMPANY
WINSTON-SALEM, N. C.

Alert and understanding supervisors plus excellent medical attention are key to their program.

THE Company has had for a long time a sincere interest in solving the problem of Alcoholism. The employee who takes an occasional drink that doesn't interfere with his attendance and job performance—or that person who can sensibly enjoy a social pleasure guided by his own practical judgment — presents no problem.

Our Company does become concerned when the use of alcohol causes trouble on the job—when because of excessive drinking, attendance and job performance become unsatisfactory.

Before proceeding any further, let's define Alcoholism. It is an illness: uncontrolled drinking characterized by alcohol dependence arising out of varying causes—neurological, systemic, psychological, metabolic, social.

In order to have an effective program to control this problem, the problem of Alcoholism must be recognized by the employee's supervisor as an illness. The illness must be studied as a problem in order to avoid misconceptions; it must be handled with logic and practical judgment. A case of excessive drinking often stems from a type of neurosis or from some domestic or personal problem. All too often the causes appear in combinations which

are too complex for the average person to analyze. For that reason and because these causes usually develop a compulsion pattern, medical attention is usually warranted. However, in any case an employee must acknowledge that he is an alcoholic and desire help. Alcoholism as an illness is progressive in nature resulting in malnutrition, anxiety, personality disorders and physical deterioration.

Alcoholism is a National Problem. It is the fourth most serious problem on the United States Public Health Service list, exceeded only by cardiovascular diseases, cancer, and arthritis. It results in billions of dollars of economic waste each year.

Two Million Alcoholics

Medical and facility costs for rehabilitation of admitted alcoholics who desire to help themselves approach eight hundred million dollars per year. What is of immediate concern to industry is that problem drinkers comprise some 3 to 4% of the labor force according to the Chicago Committee on Alcoholism. While there is considerable disagreement among the experts about the total number of alcoholics, one reliable source, the "Yale University School of Alcoholic Studies", estimates that there are some five million alcoholics in the United States, with two million in industry. This disease can sap a man's health, disfigure his family life and inflict a crippling blow upon society. National Safety Council estimates attribute 30% of 40,000 highway fatalities in 1957 to this same problem. Our own community welfare costs rise yearly as neglected children and broken homes become more familiar stories. This destructive force on our standard of living cannot be measured.

Recent statistics tell us that because of the problem industry loses thirteen million manhours and in excess of one billion dollars annually through:

(a) Absenteeism charged as "illness"

(b) Hospitalization and medical expenses

(c) On-the-job accidents attributable to alcoholics

(d) Disability payments

and (e) Pensions paid to prematurely retired employees

Indirect costs to industry run upward of ten billion dollars annually. To the bill which industry pays for this problem annually may be added the inefficiency resulting from hangovers, production slow-downs due to the loss of a team or crew member, the undermining of an active and forceful safety program, plus the tremendous blow to morale.

This, in turn, leads us to the personnel problem connected with Alcoholism. We are faced with moral connotations of this illness: absenteeism climbs, morals decay, and labor turnover rates go through the ceiling. The deteriorating effect of alcohol upon the wife, mother, and children of the employees who are alcoholics cannot be measured. Not to be lost in this array of adversities to making a profit and earning a living is a drop in productivity and the deterioration of morale in those employees who are not alcoholics.

Prior to 1949 each division of Western Electric handled the alcoholic employee somewhat differently, with varying results. However, since that time a definite policy was established based upon our experience, practices followed by acknowledged medical authorities and information from leading groups devoted to the study of alcoholism.

Our Company's approach to this problem is first through the avenue of current medical thinking which

no longer considers Alcoholism a taboo subject but rather recognizes it for the progressive illness that it is. The deterioration of the body as a result of excessive drinking frequently involves physical and mental conditions that require suitable treatment. Specialists in the field of Alcoholic rehabilitation recently have found that publicity is good. To bring the problem out into the open creates a condition of understanding and awareness.

The existence of this problem in its early stages is difficult to detect. Industry executives are always seeking ways to deal with the problem and realized long ago that rehabilitation cannot be effected by the employee alone. He needs a program. To an employee as well as to an employer, the threat of income loss and decrease of production potential can be and is serious. Industry has an investment to protect and the wage earner a way of life. Fortunately there is in existence an informal, self-supporting fellowship to help others —Alcoholics Anonymous has been most helpful with the problem and offers its services willingly.

Recognition of the Problem Case— For the employee's interests as well as the Company's, the role of the supervisor is important and he should not permit progression of the case to the problem stage through mistaken kindness. An employee has already progressed to the problem stage once his addiction to alcohol results in unsatisfactory job performance such as:

1. Lowered productivity. Perhaps not consistently lowered, but, in the early stages, it will be spotty. At times the worker's output will suffer when compared with that of his co-workers and with his previous record. As a budding alcoholic, the employee may be confining his heavy drinking to week ends and Monday will be his worst day. Tuesday will show an improvement and by Wednesday will be back to normal. As his drinking continues, ordinarily, the bouts will be more severe and of longer duration, with his production record dropping to lower and lower levels.
2. Quality of work. If he is a shop employee, the percentages of scrap and rejects will increase. If he is an office worker, he will make more mistakes.
3. Attendance record pattern will reveal that the employee (again primarily in the early stages of alcoholism) is frequently absent on Mondays and Fridays, the day after payday, the day or days following holidays. When questioned as to the reason for his absence, the excuses most heard will be: "upset stomach", "headache", "nervousness", or simply, "I felt rotten."
4. An employee who appears to be shaky or nervous at the beginning of the day, after coffee break or

ABSENTEEISM and accidents are among the most obvious consequences of alcoholism in the male employee. He loses 22 working days a year, on the average, from the acute effects of alcohol alone. He loses two more days a year than the non-alcoholic from other ailments not directly related. Fifteen hundred fatal accidents at work each year are attributable to alcohol.

—from PRACTICAL PSYCHIATRY FOR INDUSTRIAL PHYSICIANS by W. Donald Ross, M.D., F.R.C.P.

"lunch" at the bar across the street seems to be alert and much more steady. At this stage he finds the morning after is too much to bear, and he attempts to stabilize himself through drink during the working day.

5. The employee, who in addition to showing signs of inefficiency, becomes increasingly unreliable. He cannot be depended upon to carry out instructions. He will make excuses for not doing or finishing a job before even starting it. He will disappear from his work location for periods of time and will not want to explain his absence.
6. As he deteriorates further in his drinking, the employee's personal appearance may suffer. His shave will be sketchy, his general appearance unkempt. His disposition will change for the worse. He will become more difficult to talk to or reason with; there may be evidence of increasing financial and/or domestic difficulties.
7. Finally, the employee may become a safety hazard. This is probably the most serious indication of all because while in the other patterns the fellow employees of the alcoholic may be inconvenienced, where safety is concerned, there is always the unfortunate possibility that an innocent person may be needlessly injured or killed. With good fortune, however, the alcoholic's accident rate, while going up, will involve only minor incidents such as an increasing num- of cut fingers, skin scrapes, bumps and bruises.

If any doubt exists as to the legitimacy of an absence, the employee should be visited for the purpose of determining the true reason for the absence. A record should be maintained in sufficient detail to insure constructive handling of the case. The effectiveness of our program is dependent upon the supervisor recognizing the subject as an alcoholic.

The First Step—The supervisor's first step is a frank and firm talk in an effort to check the problem before the employee passes the point of rehabilitation. The initial action by supervision seeks to convince the employee that he has a problem and points up the reasons why the problem exists. The interview should be formally documented and avoid any cover-up. To ignore, hide or protect can be a distinct disservice to the employee, for at this time it is urgent to provide the necessary motivation that the employee needs to seek treatment.

The aim of the talk is to not only show him that we believe a problem exists, but is to have the employee himself see it and face it; without this realization on his part, rehabilitation will not even begin. It is also emphasized that while the company wishes to aid him in every possible way, his poor conduct cannot be overlooked. He is told frankly that if his work performance does not improve, his continued employment with the company is in jeopardy. Thus, the employee is informed that there is something wrong which requires immediate correction and rather than simply "fire him", we want to help him get back on the track.

Medical Intervention — The case that is not corrected within a reasonable time is reviewed at a higher supervisory level. Here the responsibility rests for initiating rehabilitation procedures and arranging for further interviews, medical consultation, and examination. The employee agreeing to cooperate is referred to the best agency in the community for treatment. Costs in connection with out-

side treatment are borne by the employee. The case of an employee who has less than ten years' service and is without abilities of positive value to the Company is reviewed to determine whether he should be retained on our employment rolls before we take up the question of referral to a medical consultant. In actual practice the employee is usually warned again and given one more opportunity to improve.

In the event the employee declines to cooperate in obtaining the necessary diagnoses, or refuses to undertake corrective measures, or it is determined that the employee is not an alcoholic and the rehabilitation measures would not have direct application, the necessary action would be disciplinary in nature and discretionary with supervision.

Rehabilitation Measures—The next step is for the employee to place himself under the care of a medical consultant who will provide or arrange proper treatment or seek the aid of a rehabilitative group such as Alcoholic Anonymous which has over the years been very successful in effecting rehabilitation of our employees. Disciplinary action is ordinarily deferred until it becomes evident that corrective results cannot be obtained. The course of treatment encourages the employee to avail himself of the assistance offered by Alcoholics Anonymous or other recognized rehabilitation agencies. Not to be overlooked is assistance from the alcoholic's family and church. Very often great therapeutic value can be achieved through a new job environment or other minor adjustments. The Company attempts to show the way but the action must be taken by the employee himself. Payment for absences during treatment varies in accordance with the individual case.

In the event of a relapse, leniency is in order where evidence indicates satisfactory progress and a sincere interest in self-rehabilitation on the part of the employee. Responsibility rests with supervision to make clear to the employee he is to achieve complete control of alcoholic tendencies and that continued interference with satisfactory job performance will not be tolerated.

Rehabilitation Failure—The habitual non-performer cannot be retained. The desirability of tempering the separation process by means of suspension is considered in the hope that the employee will be shocked into effective rehabilitation. In all cases the medical consultant will be asked to report fully on the case.

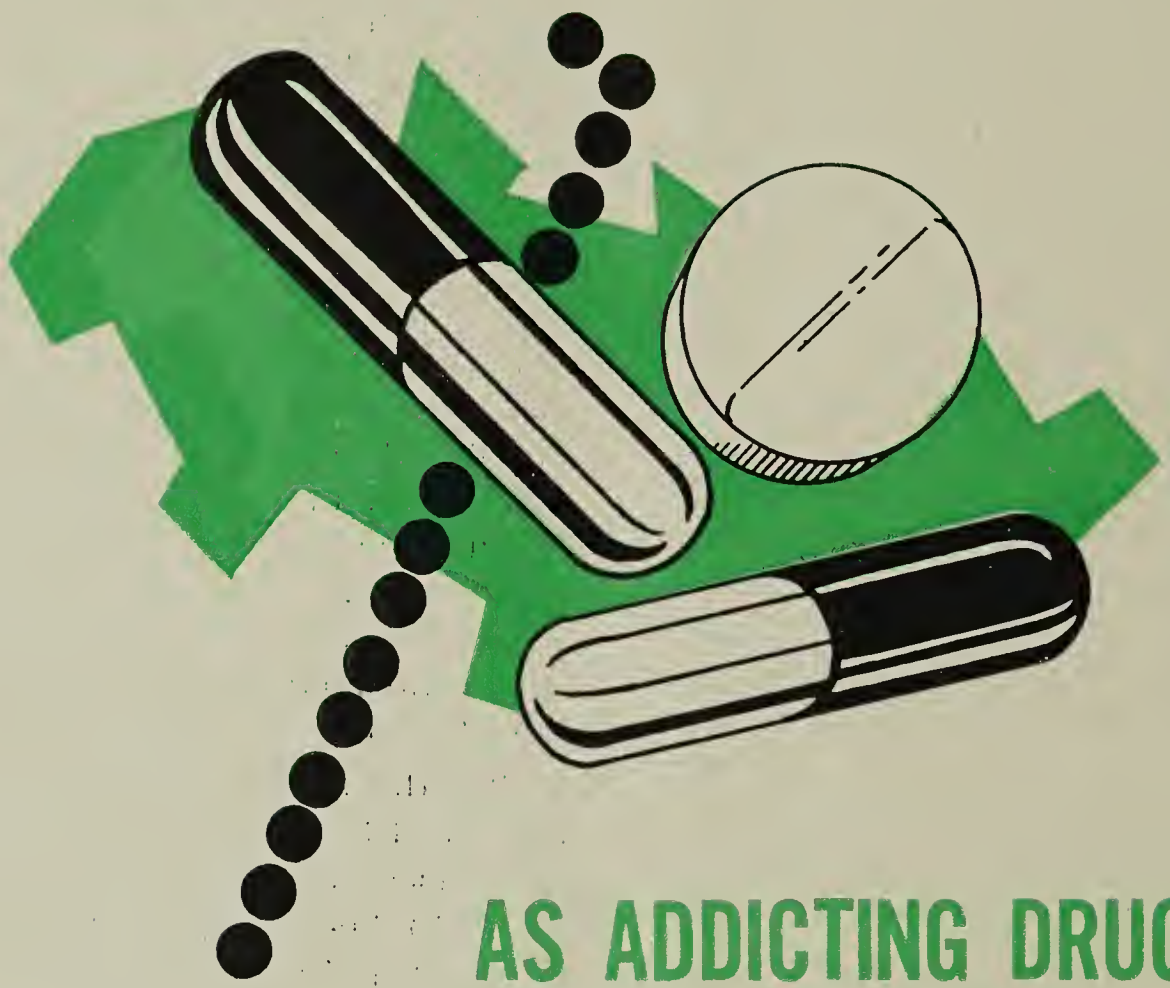
The disciplinary action taken varies to fit the pertinent details of the cases—age, service, job record prior to becoming an alcoholic, remaining potential value, degree of earnestness exhibited toward self-habilitation, family condition, community relationships, etc.

Disposition of the case is discretionary with supervision when the employee has less than ten years' service. More than ten years' service allows up to three suspensions, each more severe than the preceding. After the third relapse, consideration is given to termination of employment (separation allowance paid depends upon circumstances of case); consideration is given to service pension if employee is eligible. Alcoholics cannot qualfy for disability pensions.

An essential part of our policy is to be firm and to follow up the warnings with disciplinary action. We want to do all we can to help the employee help himself, but there

(Continued on page 31)

BARBITURATES



AS ADDICTING DRUGS

They can be dangerous and habit-forming if taken in large doses.

BARBITURATES, commonly prescribed as sleeping pills, are useful depressants of the central nervous system and if taken in small amounts under direction of a physician, produce no bad effects. But experiments have shown that these are dangerous, intoxicating drugs—that they are not only habit-forming but addictive when taken in large and uncontrolled amounts. The excessive use of barbiturates is not only harmful to individuals but presents a serious social problem.

How many persons take these drugs habitually is not known and very little statistical research has been done with regard to the extent barbiturates are used in this country. The amount manufactured in the United States in 1955 was 864 pounds. This is roughly equivalent to 3,918,-240,000 capsules or tablets of 0.1 gram (1.5 grains) each, or approximately 26 doses for every man, woman, and child in the population. While the legimate prescription volume is very large and a considerable amount is used in hospitals as anesthesia and for animal experimental work, these figures indicate that there are more barbiturates available than are need-

Reprinted from a pamphlet published by U. S. Department of Health, Education & Welfare

ed for therapeutic purposes. Abuse of the drugs is of continuing concern to police and health authorities who are increasingly aware that many persons use barbiturates as intoxicants. More deaths are caused by overdoses of barbiturates taken either accidentally or with suicidal intent than by any other poison except carbon monoxide.

A grave but generally unrecognized danger lies in the addictive nature of barbital and its derivatives. In fact, these drugs hold an even greater threat than the opiates, since persons intoxicated with barbiturates are not only more confused mentally and emotionally but also have poorer muscular coordination than opium addicts.

The more potent quick-acting barbiturates, such as penobarbital (Nembutal), secobarbital (Seconal), and amobarbital (Amytal), are the kinds most commonly used to produce intoxication. These bring the sensations sought by the addict, or the person attempting suicide, more quickly than the less potent, more slowly acting drugs such as phenobarbital and barbital.

Dangers Confirmed by Research

The dangers connected with the habitual use of barbiturates have been pointed up by research conducted in the Addiction Research Center of the National Institute of Mental Health at the Public Health Service Hospital at Lexington, Ky. Many of the patients admitted there as morphine addicts also have proved to be addicted to the use of barbiturates. Experiments with volunteer patients have yielded reliable information regarding the effects of barbiturates and ways to deal with patients addicted to their use.

Intoxication by barbiturates produces symptoms similar to alcoholic intoxication. The person affected becomes drowsy and confused, unable to think clearly. He cannot coordinate his muscular action when he walks or stands and sometimes reaches the point of collapse. He experiences tremor of his hands, lips, and tongue, has difficulty in thinking clearly or becomes inarticulate. His emotional control is unstable, and his attitude sometimes hostile though he is usually too intoxicated to carry out any harmul intent. Persons even mildly under the effects of barbiturates are a great safety hazard if they drive cars. Obviously, like the alcoholic, the individual who consumes barbiturates to the point of intoxication is a menace to himself and to others.

Addiction Characteristics

Experiments conducted at the Addiction Research Center have established the fact that the barbiturates taken habitually in large quantities produce all three of the characteristic symptoms of addiction: (1) a tolerance to the drug so that the same amount produces progressively less effect, hence the addict craves larger and larger doses; (2) physical dependence on the drug which requires its continued use to prevent the characteristic symptoms that follow abrupt withdrawal — known as the abstinence syndrone; (3) psychic dependence or habituation — turning to the drug as an escape from emotional stresses.

Withdrawal Psychosis

The experiments at Lexington confirmed that for those who become addicted to barbiturates, abrupt and complete withdrawal of the drug almost always results in convulsions and often also in a psychosis. The withdrawal psychosis resembles alcoholic delirium tremens and is charac-

terized by anxiety, agitation, insomnia, disorientation, delusions, and hallucinations.

Because of the dangerous symptoms that develop from too large doses of barbiturates, and because barbiturate intoxication is in nearly all cases associated with psychiatric disorder, the treatment must always be given in a hospital. This treatment is complex and is similar to the treatment for chronic alcoholism or morphine addiction. The drug must be withdrawn gradually under careful surveillance over a period of 3 weeks or more. Too sudden withdrawal could be fatal. The patient should remain in a drugfree environment for from 4 to 6 months. During this time rehabilitation should be carried out by means of vocational training, occupational therapy, and formal psychotherapy when possible.

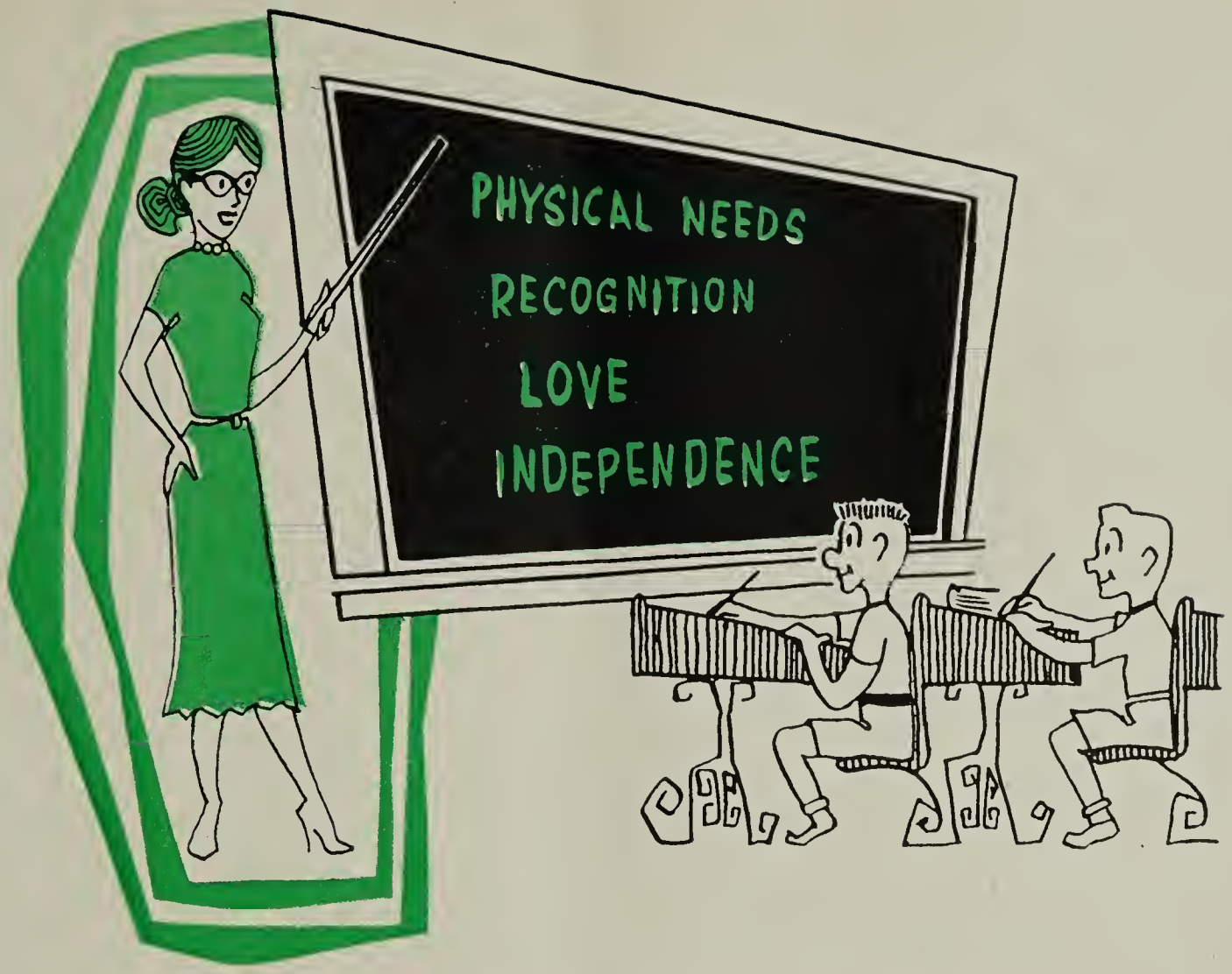
Further research is now being conducted on the effects of barbiturates. These include experiments to ascertain the relationship of the amount of drug the person has taken to the intensity of his symptoms when the drug is withdrawn. It has already been shown through experiments that addiction ordinarily does not occur unless the patient is taking 0.6 gram (10 grains) or more of one of the quick-acting barbiturates daily. Physicians warn, however, that persons taking as little as 0.4 gram (6 grains) daily for several weeks may develop a psychological dependence which causes them to increase the dosage to more dangerous levels. The experiments also showed that the intensity of physical dependency on barbiturates increases with the size of the dose taken.

Much more research needs to be done on this subject, but it has already been established beyond doubt that the barbiturates should not be used except on a physician's prescription and that medical supervision is required when a person addicted to their use is withdrawn from barbiturates.

THERE is ample evidence that the problems associated with excessive use of alcohol and improper use of barbiturates are both intensified and magnified when the two are used together. According to Dr. Harris Isbell (U. S. Public Health Service Hospital, Lexington, Kentucky): 'Severe intoxication with a mixture of alcohol and barbiturates is far more serious than severe intoxication with either drug alone.' Dr. Isbell is referring primarily to the physiological aspects of the double addiction. His comment will be supported by many A.A.'s who have tried to 'carry the message' to other 'alcoholics' who asked for help, only to discover that alcoholism was only a fraction of the problem to be solved.

To the alcoholic, perhaps the most significant fact in this brief appraisal of barbiturates lies in the parallels between chronic alcoholism and chronic abuse of sedatives. The disastrous consequences of both seem to have their beginning in certain personality characteristics which lead the alcoholic and the pill-taker alike to abuse things which others use in moderation.

—from SEDATIVES AND THE ALCOHOLIC
Alcoholics Anonymous Publishing Company



–ALCOHOL EDUCATION–
The Role of the Elementary School

BY JOHN J. PASCIUTTI

• *The product of effective alcohol education: a happy, healthy person.*

MORE and more educators have come to realize that the most effective alcohol education is indirect, especially for children in the lower grades. Research makes it clear that the use of alcohol to excess by adults may be a symptom of deep unhappiness, of tension, strong feelings of frustration, shyness, isolation, worry over failures, and of a feeling that childhood and youth have been wasted. And educators realize that one of the most important things schools can do in alcohol education is to help children grow up happy, healthy people who adjust without too much strain to their fellow men and to the busy society of which they are a part.

To put it another way, the use of alcohol is not necessarily the fundamental problem. A major part of

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Mr. Pasciutti is Supervisor of Alcohol Education for the State of Vermont. The article is condensed from a pamphlet published under the same title.

alcohol education in the elementary school consists in helping children meet their needs.

So much is being written on this subject in our time that it seems like a problem of great magnitude. The fact is that there's really nothing mysterious about children's needs. It is pretty well understood that a child first feels, then he does, and then he thinks. Good feelings must be built into the child if we are to have children whose thinking is sound and constructive and whose actions are acceptable to us and to society.

The needs of children are simple things and the literature on the subject is abundant. What it all boils down to is that happiness in life seems to come into full blossom only when the following needs are met in childhood:

1. Basic biological needs;

2. Need for success, social approval, recognition;

3. Need for love, leading to feelings of belonging—that feeling that everything is "o.k." no matter what happens;

4. Need for independence;

5. Need for harmless and constructive outlets for troublesome feelings, and a chance to talk about fears;

6. Need for people who are dependable and on whom the child may model himself.

The teacher can recognize needs like this in herself, which may help her see how important they are for children. She knows she has to be able to depend on people; she wants to be accepted and approved of; she needs to have someone she can talk to about the things that bother her. Like her pupils, she is always working to understand better what goes on in the world, seeking people and ideas as models or starting points for her own values and ideals.

Understanding teachers have a special knack for recognizing needs and helping children meet them, for they are more than usually sensitive to what goes on in children; more than usually able to help children grow into good citizens. They are people who are putting intelligence, flexibility, tolerance, and love into their work, and it is just such qualities as these that help their pupils most to grow into good citizens who will not need to turn to alcohol for escape or relief in later life.

These qualities, as they come to life in the teacher's daily work, are the key to alcohol education in the early years in elementary school. It is, at heart, simply a matter of the teacher doing the best job she knows how of working with each child, separately, and as a member of the school group, in discovering and meeting children's needs. This is important, for the school is the child's threshold to the future, his first big step away from home. This first step should not be a faltering one.

Alcohol education in the elementary years cannot be separated from educating for a sound knowledge of facts, a healthy body, or a useful skill. All of them go on together in the good school. But the teacher who is working with an eye to alcohol problems develops a special concern for good mental hygiene practices which make her especially helpful.

It follows that a daily school program that helps to build well-rounded persons, with the mental, moral, and emotional stability needed to face life and all its complexities, is an important first step in alcohol education. Equally necessary is a *positive* program of education in nutrition, health, and safety which will expand in scope as the child grows

older and progresses through the elementary school. At first the work is mainly one of establishing habits and cultivating attitudes conducive to healthful living. The contribution of good foods and beverages in building for health comes immediately to mind. Good play habits helpful in developing strength and coordination are important, too, and the earlier that approved safety practices are introduced, the better.

School people will also want to be watchful for danger signals which may mean warped personalities leading to an inability to cope with life's problems later in life. One teacher of the first grade says:

"Through everyday discussions one is able to see the trend of the child's thought in relationship to the family, home activities, playground friends, school, church, and other people. If the child is to become a well-rounded individual, we can start at the primary level to develop healthy attitudes toward these things. This leads up to the fact that he will then be well enough adjusted to life to meet responsibility and to challenge its problems.

Of course, if this plan is carried on through childhood and adolescence, these boys and girls will have the ability to think with clarity and understanding toward alcohol and similar problems."

Alcohol studies make it pretty clear that many Americans cannot carry on such necessary and normal functions as work, socializing, and mating, without a chemical "crutch." Clinical experience with alcoholics, and many case histories, provide significant clues to the reasons why satisfactory emotional and social maturity is not achieved. We cannot ignore the meaning and implications of this work if we are truly concerned with problems of adjustment.

Is it the frustration of these needs that leads people to use alcohol in excess? Researchers believe that this is at least an important factor. The alcoholic, they say, hasn't grown normally—he has stopped growing somewhere along the way. They are speaking, of course, of social and emotional growth, the growth of feelings, of the ability to relate, of the sense of responsible independence which marks the truly "grown-up" person.

How can the school help with growing and belonging? As a citizen in the democratic community of the school, a child can both grow and belong.

It is important growth, for instance, to put facts and ideas together so that they make sense. The child doing this has a feeling of satisfaction, mastery and independence.

It is growth, too, to feel rewarded for responsibility and cooperation.

It is growth to feel that the teacher is genuinely interested in the child who is doing a job, as well as in the job being done; to feel that she cares about him, as someone worth caring about.

It is an important way of belonging to do this in a framework of shared planning and shared effort.

It is a way of belonging to be regarded as a necessary and respected part of the activities of a school, not as someone outside and alone.

It is a way of belonging to feel that the school is the child's school —that it's the school of all the children, not just a place they have to come to every day.

It is fun to be growing and learning together in such a school, but much more than fun—the groundwork for effective living. And the best kind of alcohol education for this age level is going on.

THE NATURE OF

BY HENRY A. BOWMAN

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MENTAL health may be defined as the ability to function effectively and happily as a person in one's expected role in a group. It is a condition of the whole personality and is not merely a condition of the "mind," as often supposed. It is an outgrowth of one's total life and is promoted or hindered by day by day experiences, not only by major crises such as some assume.

Mental health should not be thought of only in terms of hospitals any more than physical health should be thought of only in such terms. Granted the importance of medical specialists, we still realize that a good part of an individual's physical health depends upon such day by day, in-the-home, in-the-school, in-the-community experiences as eating, habits of personal hygiene, housing, and so on. This is as true of mental health.

Mental health is also a matter of degree. There is no hard and fast line between health and illness. It is not a simple matter to divide the

MENTAL HEALTH

It encompasses one's total personality—his attitudes, his emotions, his everyday experiences.

population into two distinct groups, namely, those who should be hospitalized and those who should not. Many of us at one time or another exhibit traits and patterns of behavior which, if accentuated and continuous, would make us candidates for psychiatric care.

Personality may be defined as the sum total of the individual, that cluster of traits and characteristics which make him a person. Each person is unique. Therefore, it is better to say that each individual *is* a personality rather than to say that he *has* a personality. He and his personality are one and the same.

Everyone has the same amount of personality. No one has any more or less than anyone else, just as climate may vary from state to state but no state has any more climate than any other. When we say, "He has a lot of personality," we are using the term in another sense and are referring to selected traits such as vivacity, enthusiasm, affability, friendliness.

An individual's personality is not all readily observable. It is like an iceberg only one-ninth of which shows above the surface of the water. The other eight-ninths are an integral part of the iceberg; but for the most part they are hidden from view except as the movement of waves reveals a little more here and there, now and then. In like manner, the ups and downs of life experiences may reveal more or less of an individual's personality. But there are certain deep-lying parts which never show above the surface. This is what psychologists have in mind when they refer to the conscious, the subconscious, and the unconscious.

Some Ingredients Inborn

Personality is an outgrowth of an individual's hereditary make-up and his experience within a given culture. Hence, it is a result of interaction among these factors; and it is in part socially determined. In the strict sense, then, personality is not hereditary, but some of its ingredients are inborn. Persons differ as to aptitudes, temperament, and so on. Yet as human beings we do have common drives, interests, and needs. In these there is variation in degree; but they are found to some degree in all persons.

Basic Needs

The basic structure of personality is formed rather early in life. As one becomes older he tends to become less flexible, partly because his habit patterns tend to "set," and partly because each new experience constitutes a smaller proportion of his total experience in life. But his basic needs, interests, and drives go on. Some of these are discussed in what follows.

The need for security is apparent even in infancy. It is a basic need all through life. Many persons feel insecure for one reason or another. But a feeling of insecurity is not necessarily the same as an inferiority complex, although many people confuse the two and use the latter very loosely. A feeling of insecurity grows out of a situation in the light of which such a feeling is appropriate. An inferiority complex is a carry-over of a pattern of life formed in early years and exhibited in a situation as if it were a childhood situation because his pattern of reaction was crystallized in childhood.

Through his own interpretation of his experience each individual creates his own "world." In a very real sense this world is private and can be shared by others to a limited degree only. In one way, as we say, "no man is an island" because each person is a part of a web of social interrelationships. In another way, however, each of us "lives on a little island out in the middle of a foggy sea," as the song says. No two private worlds are exactly alike. The person's concept of himself is part of his private world. He will do what he feels is necessary to protect his *self* and his world. This protection sometimes takes such forms as rationalization, projection of blame onto others, retreat, boasting, and so on. In extreme cases it may take the form of neurotic or psychotic symptoms.

Each person has a desire and a need to love and to be loved. If he does not seem to exhibit such a desire, it is because experience has "trained it out of him" or made him afraid to do so. This desire to love takes the form of concern for the other-than-self in a mature person.

It is unfortunate that in expressing affection within the family there is often a barrier placed between

father and son. We assume that a child of either sex may express affection for the mother and the mother for the child. A girl may express her love for her father and her father for her. But shortly after babyhood in many homes a barrier is raised between father and son. There is an assumption that to become manly a boy should begin to put restrictions on his expressions of love. It is no wonder that so many men grow to adulthood with a certain hesitation in expressing affection and that so many wives complain that their husbands are not as demonstrative as the wives would like them to be.

Desire To Belong

In the rearing of girls, there has of necessity to be some training in self-protection, especially after puberty. A problem often arises when a girl learns the lesson of self-protection against exploitive, predatory men so well that she carries this same pattern and attitude into her marriage and continues to "protect" herself from her husband. Such a woman tries to be married and single at the same time.

Each individual wants to be accepted by others. He wants to feel that he really belongs to the group of which he is a natural part. If he does not have this feeling in connection with his family or school group, he may seek a sense of belonging to some other group, in some cases an undesirable group.

This desire to belong is very prominent in the early teens. It often creates a problem for young people because belonging so often implies conformity. The pressure of the peer group is difficult to resist. A sense of belonging can best be achieved when the person also has a sense of responsibility for the group to which he belongs. How to achieve a balance between loyalty and conformity to the group on the one hand, and responsibility for the welfare of the group on the other, is one of the more pressing and complicated problems of youth.

Doors of Communication

Each individual has a desire and need to communicate with others. But in many families the doors of communication are closed, sometimes very early in a child's life. For example, when a child asks questions about "where babies come from" and is rebuffed by the parent. Sometimes when the doors are thus closed they can never be reopened. Parents often complain about this problem. They say something to the effect that they know the teenager is having problems but, "He won't talk them over with us." They may even be offended if the child turns to another person as a confidant. Such parents must, unfortunately, often be told that it is too late. The doors of communication between parent and child were closed so early and left closed so long that the lock and hinges have grown

ALCOHOL education, we feel, consists in helping children grow up without the kinds of strains and conflicts that make some people take to drinking for relief. Put it another way: alcohol education is education in healthy living, aimed towards good marriages, warm and loving homes, satisfying work, and comfortable relations with other people.

—from THE ROLE OF PARENTS IN ALCOHOL PROBLEMS
by John J. Pasciutti, Supervisor of Alcohol Education, State of Vermont.

too rusty for the doors ever to open again.

Each individual has a natural tendency to grow. Each one has his own distinctive rate and pattern of growth. In many cases injustice is done when a child is compared unfavorably with others relative to his growth or development. This is due in part to the not uncommon, erroneous assumption that every child should be at exactly the same point of growth at the same calendar age.

The person's development may progress to maturity or it may stop at an immature level. If he does not become mature, there is likely to be conflict between what is expected of him and what he is able to achieve, between his personality and the role expected of him. The child in him and the adult in him are at odds.

Choices Necessary

The individual must learn to make choices. The immature person makes choices more on the basis of pleasure or pain. The mature person makes them more on the basis of value judgments or ethical principles. When an individual does not learn to make choices, there is likely to be conflict within his personality. Such conflict tends to tear a personality apart and prevent effective living.

Each person needs to learn to live with and within his own limitations. A special problem in connection with acceptance of self is that, as a group, men tend to be more satisfied with the fact that they are men than women, as a group, are satisfied with the fact that they are women. This tends to produce conflict, tension, rejection of the traditional feminine role of wife-homemaker-mother, ineffectiveness in living, and discontent. In the last analysis, no individual can fully accept his own sexual classification unless he also accepts the sexual classification of members of the opposite sex. Accepting both of these is necessary to become a whole person.

The individual wants to have a sense of achievement. He wants to be recognized by others. If circumstances and experiences are not provided through which one can achieve success and recognition by desirable means, he may resort to the undesirable. One way to do the former is to adapt expectations to the child's interests and abilities. If this is not done, for example, when parents expect a child to prepare for a vocation for which he has no interest or aptitude, there are likely to be problems for all concerned.

One of the peculiar characteristics of human beings as compared to other organisms is that humans have a tendency to reach out beyond their immediate experience. This is apparent in religion, in creative art, in human relations. Humans are not content with the world as they find it. They have a tendency to embellish and embroider experience. They have insatiable curiosity. Unfortunately many parents and teachers destroy this natural curiosity in children and youth. They thwart imagination. Some even go further and at times confuse imagination with dishonesty to the great detriment of the child concerned.

The Healthy Adult Personality

Some wise person once said, "The biggest problem of childhood is to get over it before you're forty." By implication this suggests: first, the healthy adult personality has passed through and beyond the stage-typical behavior of the formative years; second, although such a personality may exhibit the results of beneficial learning experience, it does not carry into adulthood any part of childhood

that has become fixed and crystallized in such a way that it is a permanent burden, such as, for example, an over-attachment to parents; third, the individual's development continues all through life. We might set up the following criteria:

1) On the one hand, he works for human betterment but, on the other hand, accepts most people and situations, especially minor situations, as he finds them; he does not always expect everybody and everything to be adapted to his comfort and convenience.

2) He feels himself a part of a group, especially of society as a whole, and derives his satisfactions in life more through the contributions he makes to others than through selfish, self-centered gain or pleasure. He has an honest feeling of usefulness.

3) He is aware of his relation to the universe. He is interested in religious values. To some reasonable degree his life is oriented toward ultimate reality.

4) He has a reasonable amount of self-confidence. This does not mean over-confidence. But he knows his own abilities and limitations and therefore can meet life successfully. He is not steeped in self pity. He does not feel the necessity of making alibis or altering facts to protect himself.

5) His personality is integrated. He is not torn by internal conflict—one part of him fighting against another part of him. He is characterized by a pattern of sound, consistent values. He is a whole person.

6) He approaches problems realistically and constructively. He does not evade problems and confuse his evasion with solution. Nor does he try to solve problems through worry, nagging, or complaint.

7) He has a forward look. He looks to the future not to the past. His life is not dull or empty or boring because he has live and growing interests. He does not rest on the oars of previous achievement. He does not miss opportunities in the present by gloating over the "good old days." Never for him the philosophy of "Make me a child again just for tonight." Rather he goes along with Robert Browning when the poet says, "Grow old along with me, the best is yet to be, the last of life for which the first was made."

THOSE childhood situations that mold the child in such a way that as an adult he experiences both tension and loneliness provide part of the 'seed-bed' (for later alcoholism). For example, let's consider the overdisciplined child. He's hurt by his own parents. If he couldn't turn to them in times of need you can be sure he is not going to turn to other people for help when he needs it as an adult . . . If the person is psychologically crippled or hurt as a child, so that he cannot turn to other people in times of stress, he has to turn to something; and he may turn to chemicals . . . which will reduce his awareness of a world to which he reacts with too much tension and in which he experiences too much loneliness.

—by R. G. Bell, M.D., Alcoholism Research Foundation of Ontario, Canada

TAR HEELS AT YALE

BY VALERIE NICHOLSON
SOUTHERN PINES, N. C.

At the Summer School of Alcohol Studies, thirty North Carolinians learned much and left their mark.

At Silliman Gate, John Flynn and Ann Wall.

THE 30 North Carolinians attending the Yale Summer School of Alcohol Studies last July composed the largest contingent there.

As a neat 10 per cent of the student body of 300 from 19 states, seven Canadian provinces and three foreign lands, they managed to infiltrate all over the place.

Everyone met Tar Heels, and Tar Heels met everybody. And everywhere they met the question, "Why are there so many of you?" The answer: "Because we have one of the finest of State Rehabilitation Programs, with sufficient funds provided for scholarships to teach and train."

Most of the group were there on scholarship grants. Others were sent by their churches or other agencies, while a few paid their own way.

They made their impression on Yale—and Yale made a deep impression on them. From the 47 lectures, the discussion groups and seminars, the hours of library reading, each came away with much that he could use, not only in the field of alcoholism but with human beings everywhere in conflict and stress.

No Specific Answers

They learned there were no pat answers to the problems of alcohol, but that these are all of a piece with the many vast human problems intensified in the tensions of today—the answers to be found only in the growth of human understanding.

How this understanding may be applied is now up to each one—the teachers, ministers, doctors, health and social service workers and others—including many members of Alcoholics Anonymous, dedicated to service, both professional and volunteer.

Meeting and knowing all of these people, in the friendly informal at-

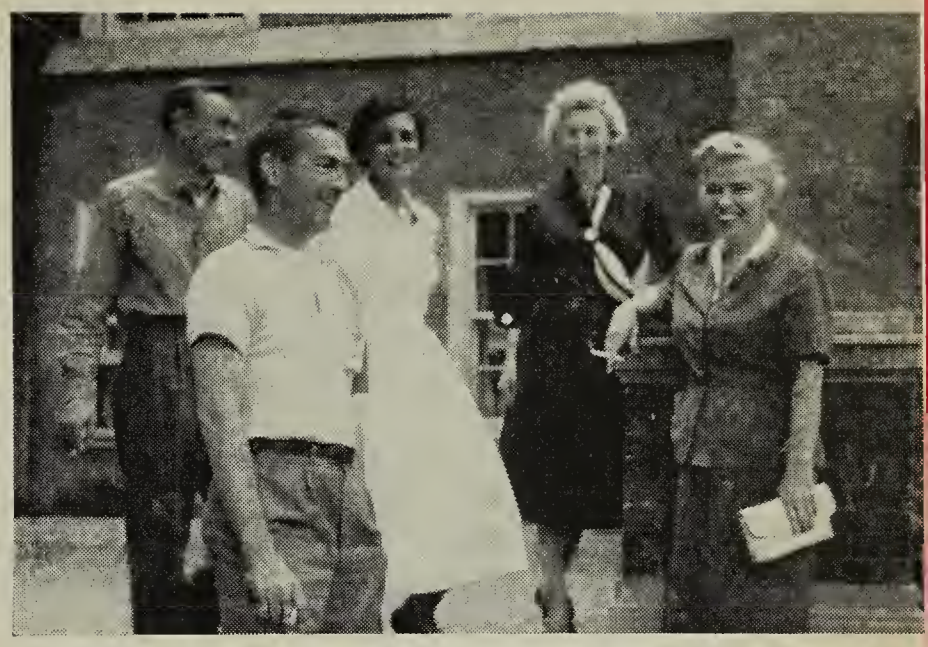
mosphere which prevailed, was an education and inspiration in itself.

The Tar Heel group in its diversity was representative of the whole.

The field of education provided the largest number, including two college teachers, Miss Jessie C. Peden of Womans College, Greensboro, and Charles B. Robson, Shaw University, Raleigh; school administrators John F. Flynn of Ruffin Rt. 2, Rockingham county; Alphonso Finch, Littleton, and Darius Johnson, Jr., Fayetteville; high school teachers Mrs. Elizabeth Luther and Miss Nell Smyre, and grade school teacher Miss Julia C. Smith, all of Greensboro. The number from Greensboro indicates a good program well on its way in the public schools.

Health Educators

In the special field of health education there were Grace H. Daniel of Salisbury, L. V. McMaham of Carrboro (with office in Burlington) and James E. Brown of Durham, all employed by the State; Howard S. Gailey of Greensboro and Frances E. Setzer of Concord, employed by their respective counties.



Talkfest—L. V. McMahan, Mgt. Davis, Ed Brown, Frances Walker, Mary Metler.

Camera fans—Dr. J. J. Wilson (right) and friend.

On Library green—Rev. "Jody" Kellermann, Grace Daniel, Frances Setzer, and Judge Willard I. Gatling.

In public health work were Mrs. Mary M. Metler, nursing consultant, from the Charlotte department, and Miss Margaret R. Keller, nursing supervisor, with the Greensboro department.

Law enforcement was represented by Judge Willard I. Gatling of Charlotte's juvenile and domestic relations court, Cecil E. Long of New Bern, probation officer, and Sgt. Carroll B. Owens of the Asheville police department; also Mason Page Thomas, counsellor with the juvenile and domestic relations court at Gastonia.

Others Attending

From the ministry came Rev. Frederick E. Still of Red Springs, Rev. R. L. Torrence and R. H. Bruhn of Asheville—also, proudly claimed by the Tar Heel group though not a student, but a staffer, Rev. J. F. Kellermann, information director with the Charlotte Alcohol Information Center. "Jody" arrived during the second week to lead a seminar for the clergy.

The only other member working professionally with alcoholism was Mrs. Anne L. Wall, executive secretary of the Rockingham County committee.

The field of mental health contributed Mrs. Frances G. Walker and Mrs. Margaret W. Davis of Wilmington, active in the New Hanover County Mental Health association. Mrs. Davis is also a devoted volunteer worker among women alcoholics.

Gene A. Bass, psychologist at the Goldsboro State Hospital, was the only member from this particular field. He received a special honor in being asked to address the nurses' group on "Projective Techniques."

Others were Dr. Jerome J. Wilson, of High Point, president of the Old North State Dental Society; A. T. (Tom) Griffin, Jr., of Goldsboro, industrialist and volunteer worker, and Mrs. Valerie Nicholson, Southern Pines, news reporter, publicist for the Moore County alcohol education committee.

Some former or adopted Tar Heels were welcomed by the group—Mrs. Anne Packard, the former Anne English Bagby of Chapel Hill, now a medical secretary in Baltimore and volunteer worker with women in prison; Lt. Herman McG. Kennickell, formerly of Asheville, now a chaplain of the Episcopal church with the U. S. Navy, based on Guamtanamo Bay; and Joseph Pack of Trenton, N. J., a public health engineer and graduate of the University of North Carolina.

Intensive Study

Learning became a tough proposition at times for some of those who hadn't been to school in a long time. The course is concentrated and intensive, on a high academic level, put on by some of the foremost scientists and scholars in this and related fields. They tackled the subject from all directions—the sociological, physiological, psychological, historical, statistical. While most of the lecturers were Yale faculty members with names familiar to all who read the literature of alcohol (Bacon, Keller, Jellinek, Greenberg, McCarthy, Snyder et al) others were drawn from a half-dozen States.

They ripped apart old misconceptions (not always a painless process) to pour new knowledge into the void from seemingly inexhaustible reservoirs of information. Yet it was made plain that only the threshold of true knowledge has been attained, in a subject as wide as civilization itself.

It was a rich adventure of mind and spirit—and if it is true that to learn one's own ignorance is the be-

ginning of wisdom, then 30 Tar Heels began to be wise, in that exciting month at New Haven. And wise they must be—for, the speakers assured them, they must assess for themselves all they have learned, relate it all together and come up with their own answers—forge their own weapons in the two-pronged attack on alcoholism: (1) getting at the roots of a great public health problem in the interest of prevention; and (2) working with individual fellow humans to alleviate their suffering, one by one. These are vastly different challenges, to be met in very different ways.

The Tar Heels came home hoping that more and more who are eligible for scholarship grants will use them for the best weapons in both fights are—more and more informed people.

Unforgettable Experience

The experience of Yale itself they agreed was one never to be forgotten. Amid the grey spires and ivied towers in the heart of colorful New Haven, the School of Alcohol Studies has its own quiet corner—beautiful Silliman College, one of the 10 self-contained quadrangles where students live, work and play together.

Men students stayed in the handsome dormitories surrounding the green lawn, to which three great wrought-iron gates provide entrance. The women were in the modern Women's Graduate Dorm, a half-block down elm-lined Hillhouse Road. Lectures, discussion group meetings, seminar sessions and film showings were held in the auditorium of the majestic Sterling Law Building a block away.

Enjoyable Fellowship

At Silliman, the students lived a life of "togetherness" in the 5,000-volume library, lounge and cafeteria. The vast diningroom with high mullioned windows and richly paneled wall was the scene of many earnest discussions, over delicious meals and ever-flowing pots of coffee. You join what group you wish, take part in whatever conversation sounds interesting to you—or if you're in a "thinking" mood and don't wish to talk, that's all right too. The Tar Heels spread out into every group, meeting a welcome everywhere. They got together only at three prearranged meals, also for a special meeting with George Adams, ARP educational director, when he came up from Raleigh during the final week.

On weekends, they took off in every direction—to see the Shakespeare plays at Stratford or visit other summer theatres nearby, to hear the Boston Symphony at Tanglewood, to the beaches or New York. However, most spare time, including the weekends, found many in the library, studying, browsing—learning as much as possible in the allotted time, which soon grew all too short.

"I sure wish I had my wife back," murmered the sad fellow at the end of the bar.

"What happened to her?," asked the fellow next to him.

"I traded her for a case of Scotch."

"Aha! Now you're beginning to realize that you really need her—you really love her, huh?"

"Nah. I'm thirsty again."

ALCOHOLISM AS A COMMUNITY HEALTH PROBLEM

BY EDWIN M. FUCHS, M.D.

Reprinted by permission from The Alabama Challenge, April-June, 1957 issue

- *Poor community attitudes can thwart effective public health measures.*

IT is important that we know the nature of alcoholism and the measures that can be taken by individuals and the community to influence (1) the rate of incidence of the illness and (2) the number of individuals who will be able to obtain help with their problem. In considering these factors, it seems wise to begin at the point that relates the problem of alcoholism to public health.

There are various facets which may be considered in viewing the scope of public health. The fundamental concept in the field of public health is the relationship of the objectives of public health to the people who benefit from it. Public health is most intimately concerned with man and man's ability to enjoy a

certain amount of freedom during his life.

Man is a social being and, as such, is always a member of society. When a man is ill, the illness is not only in the man but it is also related to the public attitudes about his particular illness and the knowledge the community has of constructive treatment measures. It is not possible to separate the individual from society. The concept of a man who has an illness we call pneumonia is valid, but the idea of pneumonia as an abstract phenomenon is not.

Society's View

We must consider the way in which society looks at the particular illness. We have had examples in the past where community attitudes largely determined the length of therapy and the manner in which a particular disease would be treated. In ancient times, the community adopted such measures as ostracizing and banning sick members. In modern times there have been difficulties relative to the detection and treatment of tuberculosis and venereal disease. The difficulties in developing effective public health programs to cope with the latter diseases clearly revealed the manner in which the community could thwart effective public health measures because of lack of knowledge and adverse attitudes.

There are various ways through which the community can promote the health of its members. The community can organize local action groups to pressure the constituted authority into taking action on a particular problem. The advent of the innoculation and vaccination procedures for school children, for example, resulted from community pressure group activtity. The next obvious step is for the community to establish health services to aid the ill and retard or check the spread of a contagious disease. Finally, it is important that the responsible health agents, through a process of education, achieve some acceptance and understanding of the illness and its ramifications. This must be done in such a way that adverse attitudes and misinformation — operating to prevent a person from seeking adequate treatment — become a constructive force which encourages individuals to seek treatment.

There are various factors which cause a community to develop interest in a public health problem. The personal safety of all members of the community is an important motivating force, particularly with respect to communicable diseases. The community's loss of certain benefits because of the existence of a particular illness may cause concern. If the individual victim is not able to work productively, the entire community suffers a loss. The community may become concerned about the cost of the problem by noticing the unreasonable amount spent on a particular facet and decide it might be wise to consider treatment or prevention.

Costs In Many Areas

This cost can be manifested in many areas other than in the actual health area. Regarding alcoholism, for instance, there is the cost of law enforcement; there is the cost incurred where persons are forced to seek aid from community agencies because of their own lack of productive work; there is the direct cost of the medical care these people must be given when the need for hospitalization arises.

Alcoholism can be defined as an addictive illness in which an individual drinks excessively to the point where his social, economic, or family

life is disrupted. Even when he is able to perceive that his life is coming apart at the seams in some areas, he is unable to alter his behavior.

In considering any addiction, we should be interested in the nature of the addiction, the factors capable of being isolated which seem peculiar to the addict, and the problems the addiction creates for the community as a whole.

Alcoholism—An Addiction

Alcoholism as a disease can truly be considered an addiction. A characteristic of any addiction is that the addicting substance is able in some way to alter the mood of an individual. The substances able to do this are given the general name of pharmacolthymic substances — meaning a drug that is capable of altering one's mood level. For almost every substance that is capable of producing an addiction, there exists—in addition to the addicting disease that may be related to it—a substantial body of evidence to indicate that many people are able to use the addicting agent without harm. The question of whether elimination of the agent would at the same time produce elimination of the harmful condition must take into account its beneficial effect on those not susceptible to its addicting properties.

Our federal government long ago recognized the importance of a specialized treatment facility for the problem of addiction by establishing the Public Health Service Hospital in Lexington and the Public Health Service Hospital in Fort Worth. It also recognized the need to adopt screening procedures to determine addicting qualities of certain substances and prevent their dissemination where widespread harm would evidently occur. This program—in which the possibility of addiction is considered in pain-relieving preparations by exhaustive clinical trials at the Public Health Service Hospital in Lexington—has been imminently successful in regulating the introduction of new preparations in the narcotic field. It has also given us much insight into the nature of addiction with substances which are basically morphine or morphine-like derivatives.

Five Basic Addictions

In this writer's opinion, there are five addicting substances. These are narcotics, barbiturates, alcohol, food, and work. The substances can roughly be divided into narcotics and barbiturates on one side of alcohol and work and food on the other side, with respect to the degree of community acceptance and the difficulty in obtaining each. Narcotics and barbiturates are much more difficult to obtain than alcohol, food, or work.

Since food and work are considered by the community as beneficial forms of addiction, the community does not feel moved to do anything about them. The community does not attempt to organize a program that restricts the availability of food to the caloric needs of various members of the community. It assumes that the individual in his wisdom is going to be able to perceive his difficulty in controlling his food intake and will establish self-regulatory measures. However, abundance of preparations designed to regulate food intake reveals the extent of this problem in the general population. This is an invitation for some type of community action at some level toward enlightening the public with a more factual presentation than that which they receive from the commercial media.

In considering work as an addiction, one can compare its effects with those resulting from an addic-

tion to narcotics, barbiturates, or alcohol. It is difficult to understand why we have divergent views which allow the acceptance of the individual who works so intensely that he has no time to make a contribution to his family, friends, or community —other than in a purely monetary way—and condemn the person who makes no contribution to his family, friends, or community because he is so concerned with staying in a mood apart from his community that he is unable to establish the necessary relationship.

Addictions Related

There have been studies conducted which seem to show that the alcoholic is susceptible to relatively small amounts of addicting substances other than alcohol. This indicates that the potential for addiction is relatively great when he uses some type if narcotic or barbiturate. The alcoholic has demonstrated, by his difficulty in handling alcohol, an inability to control his consumption of a substance capable of altering his mood; therefore, we would expect that, with other substances also capable of altering the mood, the inability to control consumption would be equally as difficult for the alcoholic.

It is easy to recognize the relationship between the substance and the addiction. It is more difficult to critically evaluate whether or not the substance is the sole concern toward which the community should direct its efforts. A great deal of confusion has resulted because prominent pressure groups take extreme positions on the question. One pressure group tries to impress the community with the moralistic connotation of the individual's depravity, and argues that this condition is something that can only be cured by an elimination of the substance and reformation on the part of the individual. The other pressure group emphasizes the benefits the community receives from the moderate use of the substance and the financial gain that accrues through taxation.

The extreme views leave much to be desired. Neither takes into account the necessity for some type of constructive activity on the part of the community with respect to the problem. Both of them place primary responsibility upon the individual. But the evidence that has been collected so far in the field of alcoholism indicates that the individual is unable to cope with his illness without help. The moral approach may satisfy the needs of some alcoholics. The physical approach—restoring the organism to its maximum level of physiological function through the use of medicine—may answer the problem for another group. A number of alcoholics are using alcohol to get rid of the symptoms of a severe underlying functional disorder. For the latter, the psychiatric approach may prove to be the most rewarding.

Alcoholics Have Problems

However, the vast majority of alcoholics are complex individuals with moral, physical, and psychiatric problems. We cannot begin to attack any of the alcoholic's problems until his primary problem is under control. There is no way to approach the many facets of alcoholism unless we first understand the ground rules which must be applied in each and every case. We cannot hope for success unless we firmly establish a program of sobriety and then use psychological, medical or moral methods to deal with the problems arising after sobriety has been established. The alcoholic, by changing his mood, finds a release, or a relief, from a

13 STEPS TO ALCOHOLISM

1 Like many people, the potential alcoholic begins to drink in a moderate, sociable way.

2 "Blackouts" occur—not "passing out," but loss of memory for part or all of a period spent drinking.

3 Alcohol begins to mean more to the potential alcoholic than to the people around him who may also be drinking.

4 The alcoholic begins to lose control—he starts out to have one or two drinks and consistently winds up drunk.

5 The alcoholic begins to think up excuses for his drinking.

6 He starts to need "eye-openers" in the morning to face each new day.

7 The alcoholic chooses to drink alone, preferring the private, distorted world of his own imagination.

8 He becomes antisocial—not just avoiding other people, but picking fights with them.

9 Real benders occur—periods of blind, desperate drinking during which the alcoholic will do literally anything to get more alcohol.

10 Deep remorse, and deeper resentment—the alcoholic at first condemns himself bitterly and then turns to hating the world and everyone in it.

11 A deep, nameless anxiety, a vague fear of retribution attacks the alcoholic and stays with him.

12 He finally realizes that drinking has him licked—his excuses for drinking no longer satisfy even himself.

13 He gets help . . . or he faces a complete breakdown.

Which Step Are You On?

situation that he considers unbearable. As long as this type of mood change continues, he is partially solving his problem. And there is no way that you can approach the problem for a different solution until he is willing to bear some of the pain and unpleasantness he has found relief from long enough to turn to another party for some type of critical evaluation.

The community has an extremely important role to play in what will be done eventually about alcoholism. Once organized and in possession of the basic facts about alcoholism, it will be able to direct efforts along constructive channels. There is no way for the community to ignore its responsibility or delegate it away. Any sick person is a part of the community, and as long as he lives in it, part of the community is sick. Until such time as he is isolated and identified and constructive treatment is undertaken, the community as a whole cannot be well. This healing approach is impossible when the community's attitudes are such that the opposite of isolation and identification results.

This is not an illness to which we can apply the inheritance of ignorance that has come to us from our forefathers. This is an illness that demands of each of us an intelligent analysis of the factual material dealing with its diagnosis, treatment, and cause. Armed with this kind of understanding, we will be in a position to influence the community to accept the sick part of itself. If approached in the proper way, it will be possible for us to treat this part and, in learning the proper treatment and studying findings which reveal why alcoholism exists, arrive at a body of truth we can apply in the future to attempt the next logical step—prevention and gradual elimination.

Western Electric's Plan

(Continued from page 9)

has to be an end. As long as he is making an effort, we'll go along with him. But the final results will rest upon the employee's own efforts.

This probably sounds like a lot of hard work—it is. There are frustrations, discouragements and angering situations. We are dealing with human beings, and there is no secret formula or easy solution in the rehabilitation of the alcoholic employee. What might have been successful for one employee may fail with the next.

Conclusion—We try to keep our policy flexible, realistic, and discretionary so that the Alcoholic problem can be handled consistently through the different circumstances that may develop, either to the successful conclusion of the rehabilitation measures or to termination of employment.

We make no claims to having all of the answers—but these aspects of our policy have been tested and proved to be basically sound:

1. The supervisor is the key person.
2. There must be certain standard rules on handling the alcoholic employee.
3. Some respected person must be in authority who can medically and psychologically evaluate the employee. In our case, it is the company doctor.
4. Along with this, firm disciplinary action must be taken to stimulate the employee to help himself.

We subscribe to this thought: "If we can help in the rehabilitation of even one employee, all of our efforts have been worthwhile."

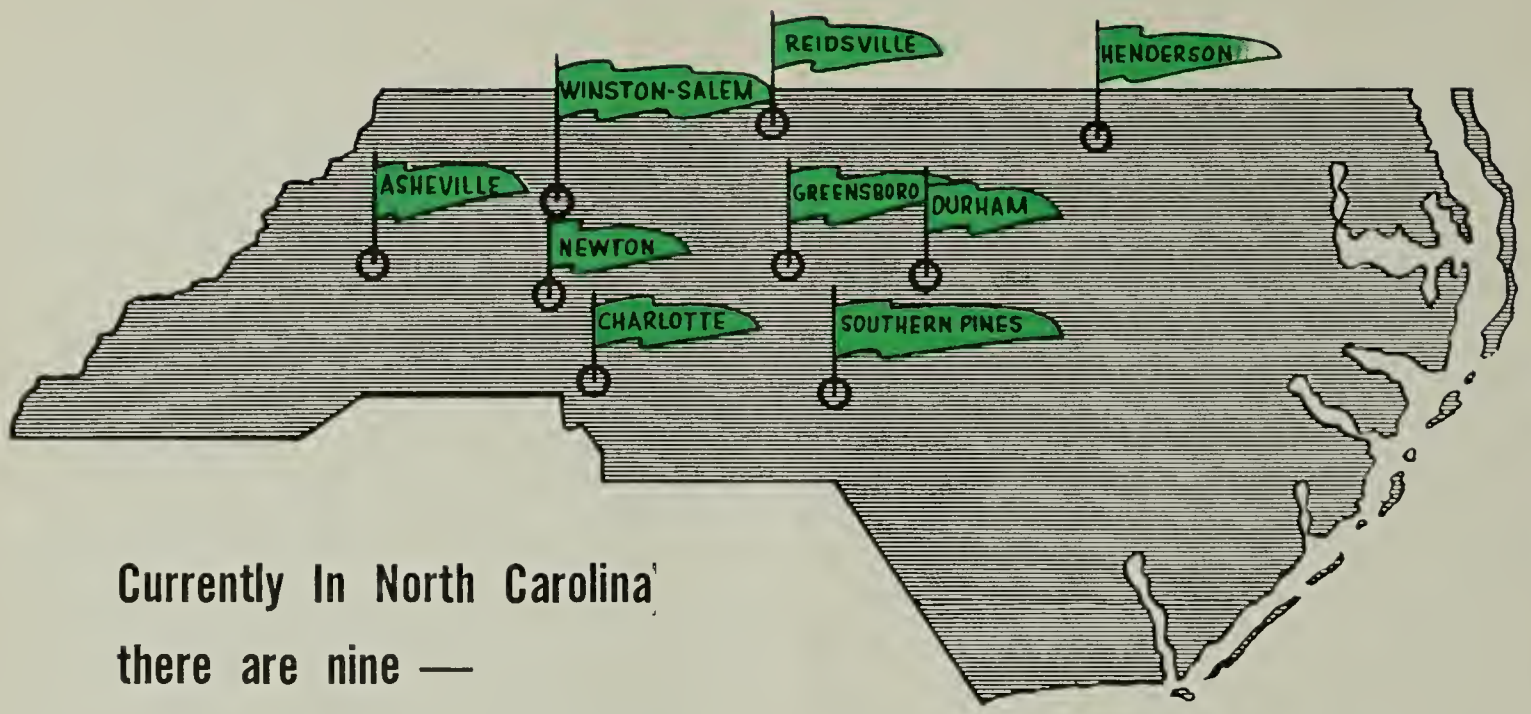
Announcement

CHANGE IN ADMISSION POLICY AT THE NCARP TREATMENT CENTER, BUTNER

Dr. Donald Macdonald, Medical Director of the NCARP, has announced a change in procedure for patients seeking admission to the Alcoholic Rehabilitation Center, Butner. Beginning immediately all applications for admission and all other correspondence should be addressed as follows:

The Medical Director
Alcoholic Rehabilitation Center
406 Central Avenue
Butner, North Carolina

Patients are now being admitted directly to the Center at the above address, whereas, in the past, they have been admitted through the John Umstead Hospital.



Currently In North Carolina there are nine —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—

Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)
Educational Division, Board of Alcohol Control
West Wing, Parkway Office Building, Asheville
Margery J. Lord, M.D., Administrator
William J. McCord, Educational Director

CHARLOTTE—

Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellermann, Director
William Hales, Associate Director

DURHAM—

Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Executive Secretary

GREENSBORO—

Educational Division, Alcoholic Board of Control
Greensboro
Mr. Worth Williams, Executive Secretary
Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Mr. Worth Williams, Executive Director

HENDERSON—

Vance County Program on Alcoholism
Reverend Edward Laffman
Route 2, P. O. Box 88A, Henderson

NEWTON—

Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton)

REIDSVILLE

Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SOUTHERN PINES—

Moore County Alcoholic Education Committee
Rev. Martin Caldwell, Director
P. O. Box 1098, 350 S. Ridge St.
Southern Pines

WINSTON-SALEM—

Forsyth County Program on Alcoholism
Woodland and Seventh Streets, Winston-Salem
Mrs. Inez Wolfe, Coordinator

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

NOV.-DEC., 1959

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Making The Most Of Maturity

Reorganization Of The NCARP

Sam, The Half-Man In Industry

State, Local Alcoholism Programs Meet

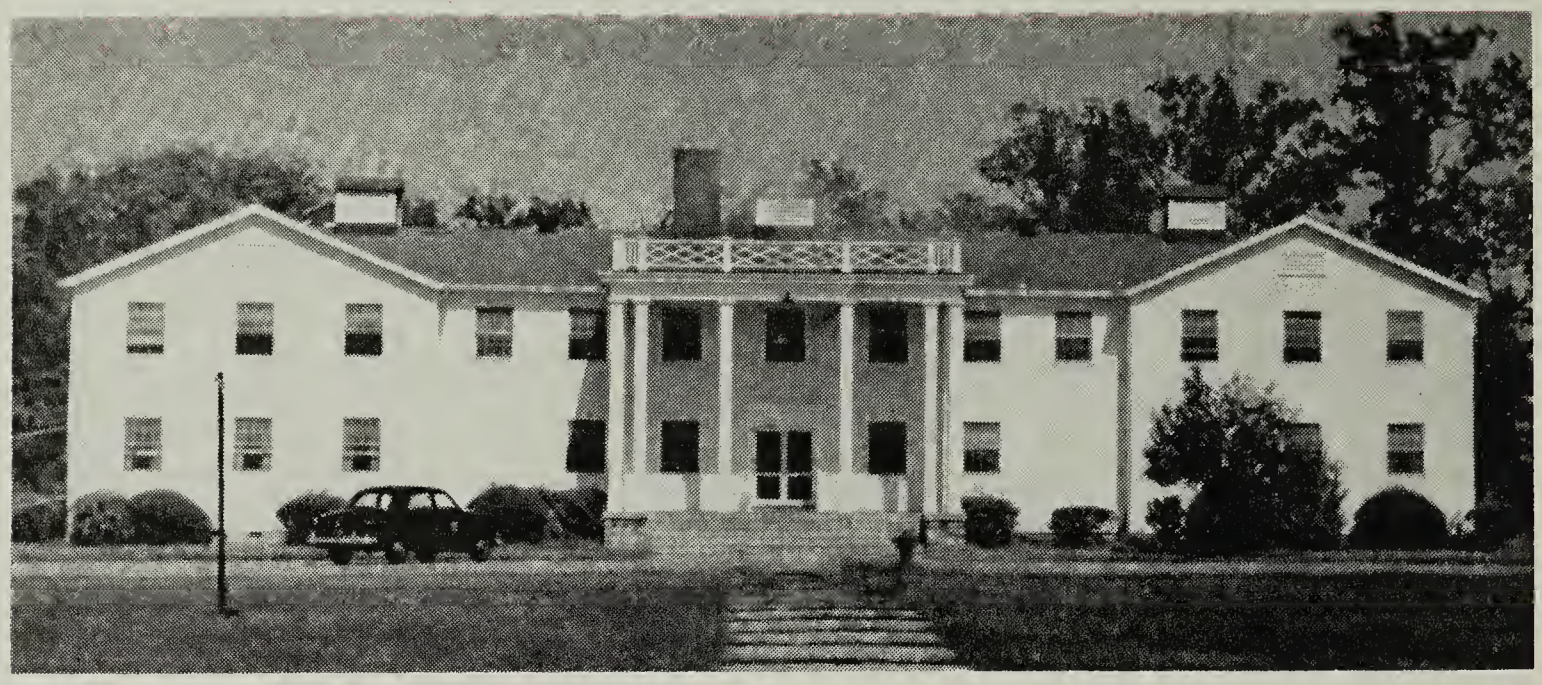
Two Drinks And The Driver

Alcoholism And Probation

What My Chip Means To Me

News From 'Round The World

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday

Patients must be sober upon admission, and in good physicial condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

GEORGE H. ADAMS
Educational Director

DONALD MACDONALD, M.D.
Medical Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

INVENTORY

VOLUME IX NUMBER 4

NOVEMBER-DECEMBER, 1959

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

JACKIE RANSDELL
Assistant Editor

ELEANOR BROOKS
Circulation Manager

This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it. Manuscripts invited with understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

DURHAM: Dr. Thomas T. Jones, President of the Durham Council on Alcoholism, has received a community service award for his outstanding contribution to the welfare of the community. Our warmest congratulations to Dr. Jones upon receipt of this honor. A tireless worker, he devotes much of his time and energy to helping his fellowmen.

JOHANNESBURG, SOUTH AFRICA: At least one person out of every 30 men, women and children in the South African European population is an alcoholic, according to an estimate by officials at "Northlea," a treatment center for alcoholics located just outside Johannesburg.

PARIS, FRANCE: The French Government's High Committee of Study and Information on Alcoholism, set up when Pierre Mendes-France was Premier, is engaged in a nation-wide educational campaign against excessive drinking. Evidence of its work is seen in subways and buses and on billboards and sides of houses throughout France. The committee believes that it is making progress, particularly among younger people, with its educational programs. In 1957 and 1958 the death rate and hospital admittances for alcoholism fell off, although the committee feels it is still too early to tell whether the trend will continue.

RALEIGH: Newest member of the ARP's Raleigh staff is Miss Jackie McCarthy (after December 12 she'll be Mrs. Ernest Ransdell), who moved into the Assistant Editor's desk in mid-August. Jackie is a 1955 graduate of the University of North Carolina and later earned the M. A. degree in Communications from UNC. The staff bids her welcome and best wishes in her two new careers as communications specialist and housewife.

NEW HAVEN, CONN.: It has recently been announced that the 1960 Yale Summer School of Alcohol Studies will be held from June 26 to July 21. Enrollment will be limited to 275 students.

NEW YORK: H. David Archibald, President of the North American Association of Alcoholism Programs, has announced that the NAAAP will undertake a five-year international effort to clarify the alcoholism language and to improve understanding of alcohol problems. The sum of $66,000 has been allocated for the study by the U. S. Department of Health, Education and Welfare through the National Institute of Mental Health.

HOUSTON, TEXAS: The Gulf Publishing Company has just released a new book on alcoholism, "The Drinking Problem—and Its Control," by Dr. C. A. D'Alonzo, Assistant Medical Director of E. I. DuPont de Nemours & Co. In his book Dr. D'Alonzo outlines a rehabilitation program which can be applied by any company interested in cutting manpower costs and helping alcoholic employees to solve their drinking problems.

MONTGOMERY, ALABAMA: The State's alcoholism commission has been officially named ALABAMA COMMISSION ON ALCOHOLISM. This replaces the old title of Commission on Education With Respect to Alcoholism, which was adopted by the Legislature when the agency was created in 1945. The commission is attempting to develop a balanced program with appropriate emphasis on education, treatment and research. It has two outpatient treatment clinics for alcoholics, located in Birmingham and Montgomery. Among its many educational activities, it publishes a quarterly periodical called **The Alabama Challenge.**

SOUTHERN PINES: Reverend Martin Caldwell will continue to act as director of the Moore County Alcoholic Education committee, according to Mr. John S. Ruggles, chairman. Mr. Caldwell took on the post as a temporary measure following the transfer in July of Rev. Robert L. Bame, of the First Methodist church.

ONTARIO, CANADA: The Ontario Temperance Federation states that Belgians are the leading consumers of beer. They consume 31 gallons per year, per person (man, woman and child). Luxumbourg, Australia and New Zealand follow in that order. West Germany and the United Kingdom rate 18 gallons per person. Canada's consumption is 13 gallons per capita.

RALEIGH: The graduate training program for Rehabilitation Counselors at N. C. State College is supported in part by the Office of Vocational Rehabilitation Department of Health, Education and Welfare. A number of traineeships are available to qualified students. Applications are now being accepted for graduate fellowships (four in number) of $900 per semester for the Spring term of 1960.

Congratulations to the Program

During my four and a half years in North Carolina I worked at the Veteran's Administration Hospital in Fayetteville and had a great deal of experience with the treatment of alcoholic patients. I attended two of your Alcoholic Institutes for Nurses, which I thoroughly enjoyed. I want to congratulate you on the wonderful work that your organization is doing towards alcoholism. I always look forward for each copy of "Inventory." Also want to thank you for your wonderful "Nurses Source Book on Alcoholism" which I recently received. May you continue your good work always.

Mrs. Shirley Gustafson, R.N.
San Angelo, Texas

Nice Addition to Library

Would it be possible for our School of Nursing Library's name to be placed on your mailing list for INVENTORY? I have seen some of your journals and found them most helpful and informative and especially for our young students.

Allice P. Gresham, Librarian
Jewish Hospital of Saint Louis
St. Louis 10, Missouri

Wonderful Articles

I am a member of the Whitehaven (Tenn.) Al-Anon Group and am very interested in getting literature pertaining to alcoholism. Your "Inventory" had some wonderful articles in it. I would appreciate receiving "Inventory" and feel that our Group as a whole would benefit by it.

Mrs. H. L. F.
Memphis 6, Tennessee

Clerk of Court Writes

For some time now, the Clerk of Court's Office has been receiving your bi-monthly magazine "Inventory." It has helped us a great deal in understanding alcoholics, and in dealing with our customers who desire to commit a member of their family to some institution for treatment of alcoholism.

J. P. Shore
Clerk Superior Court
Greensboro, N. C.

Helpful Publication

Your publication, INVENTORY, certainly is helpful to me as a social worker. In my work I see much of the results of homes broken because of alcoholism.

Stella Pearce
Itasca, Texas

Wealth of Information

I am a volunteer worker in the "Women's Studio Club"—a home for sick alcoholic women. Also I am an active woman in A.A. 12 step work, being an arrested alcoholic myself. Your journal has in it a wealth of information of the type we are seeking in order to help ourselves and the other sick and helpless alcoholics.

M.A.S.
Seattle, Washington

VOL. IX NO. 4 INVENTORY NOVEMBER-DECEMBER, 1959

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Making The Most Of Maturity

Prescription for happiness in later years: a healthy body, a serene mind, economic security, and a worthwhile hobby.

Condensed and reprinted by permission of the John Hancock Mutual Life Insurance Co.

"WHEN I grow up!" Can you remember back to the day when these wishful words were often on your tongue? Even your play was influenced by this dream. Was your "make-believe" concerned with keeping house or tending store? Or were you of a scientific turn, a builder of castles, a nurse for sick dolls, or a frowning doctor? This play in imitation of grown-up life was, in a small way, preparation for it. It is clear that the serious side of your youthful activities was directed toward the future. Your schooling helped to fit you to make a living. You sought a mate—or were sought after—to make a home. Yes, you looked forward with keen anticipation to

the glorious years when you'd be free to live your own life, as you sighed, "When I grow up!"

"When I grow old!" How often do these words pass your lips, now that you have reached the fullness of your maturity? Perhaps your hours are packed too full now to give thought to your future. Or it may be that you deliberately close your mind to the contemplation of what life may be like in old age. You lull a troubled spirit by promising, "I'll cross that bridge when I come to it." But is it safe to wait? It's later than you think.

A short-sighted view of life can lead to tragedy. Though each of your days, while you are in the forties and fifties, may seem full to overflowing, the years have a way of turning quite empty later on in the sixties, if you have not by then found something new and suitable to do. Yes, the autumn of life may prove to be a time of idleness, loneliness, and boredom unless you make intelligent plans for it. On the other hand if you have prepared yourself for the new and different life you will lead then, your time of leisure may prove as rewarding and satisfying as any part of your existence. Truly old age is what we make it.

Something New

But why need life be different in the years to come, you challenge. It will be different: rest assured of that! For one thing your family obligations will be less demanding, for your children will have gone to homes and jobs of their own, and your work too will have to be lightened, if you have not been retired. And you will be glad that these burdens have been lifted. But—and this is a big "but"—you'll want something new, and different, to do, something within your capabalities to take the place of the business or family cares you drop. And it is not safe to wait until the day of retirement comes to cross that bridge of leisure-time activities, for by then you may have neither the time nor the energy left to prepare for that new and different life.

The nub of the matter is this: these new and different ways of living, suited to the changed person you will become, call for preparation well in advance. For this apprenticeship to the new must be served while you still retain the energy to break into new ground, to master new skills or gain new knowledge. So we repeat: you may be courting trouble if you wait to begin your apprenticeship, for when old age comes, that all-important store of energy may have seeped away. At forty many men and women have begun piano lessons to taste for themselves the joy of creating music. At sixty? Well, for all but the one in a million, it's too late.

But, you may be arguing, I have no intention of changing. I like my life as it is: I've a good job and I propose to hang on to it. A generation or two ago most Americans made their living on farms or small businesses or neighborhood industries. In those bygone days, men could, and usually did, continue on into old age, living and working in much the same way, their long years of experience compensating in some part for waning physical powers. For most of us, times have changed. Today the great majority of us are employed in commercial enterprises, in which the work of many is dependent upon the production of each in his group. We are, in effect, cogs in a vast machine and a cog cannot slow down; it must keep going at the set speed, or the progress of all is slowed.

Even though some of us may not be tightly meshed cogs in the world of business, if we see life whole, we

do not want selfishly to "hang on" to a job after our productiveness begins to wane. We will want to step aside in order to let younger men and women behind us have their day while they are still in the fullness of their prime. But we will not want to quit altogether. Rust sets in when movement stops. That is why we must have some new objective for the later part of life.

Vitality of Body

There is more to successful retirement than just not rusting. When we've given half a life-time in the service of one cause, we begin to feel some loss in imagination and zest for the day's work. But when we've contributed our full share to the world's work and we turn to something suitable, we may find to our surprise that we enjoy a sort of "second wind." However, we will uncover this unsuspected store of vigor only if we still retain that essential vitality of body. So the fellow who clings too long to his job may find that he pays a heavy penalty for shortsightedness.

Very well, you agree, perhaps it may be wise not to wait. What can I, in these busy days, do about preparing for the leisure years to come? There are four ways in which you can prepare yourself. You can provide, as well as circumstances permit, for those special comforts that older people need and enjoy. You can do your best to keep your body in health. You can take pains to keep your mind young and pliable. Finally, you can embark upon a hobby to add interest and meaning to your leisure years.

The subsistence needs of old age for the majority of employed men and women will be provided by the benefits of the Social Security program. Of more importance to the thrifty is the interest in supplementing the Social Security benefits through adequate personal or business retirement plans on an individual or on a group basis. But financial security is not the sole preparation we need to make for our retirement. We must have something to live for as well as to live on.

Nearly everyone gives lip-service to health, but precious few do much else about it. On all sides we see intelligent men and women going at to hard a pace, overdoing in work and play, neglecting the commonly accepted rules of healthful living, and ignoring symptoms of physical disabilities that they must know can only grow worse with neglect. What can the prudent man or woman do?

First, he must acept the fact that, through the years, the body slows down in all its functions. He will suit his way of living accordingly. Man is at his physical best at about twenty-five, and by forty there are more evidences than an occasional gray hair to remind him that a change is underway. It should be clear that when middle age is passed, it is necessary for one to gear all his activities to his slowly ebbing endurance. Fortunately, there are many quiet sports and absorbing hobbies that may properly be carried over into later years. In the matter of strenuous activities, common sense should tell the observant person what and how much is suitable to his condition, but the prudent man will have his judgment bolstered by medical examination and advice from time to time. As common sense is needed in the matter of exercise, so it is with rest. Although older people seem to require fewer hours of sleep at night, they do need more frequent rest periods during the day.

When all is said, the satisfactions of the "philosophical years" come more largely from within, than from without. Even wealth and a robust

body can contribute little to happiness if unfortunate habits of mind have warped character. Sound mental health, like physical health, is helped or marred by life-long habits. So whether that older, but new person you are to become will prove to be an aimless and unhappy man or one who knows great contentment, depends in part upon the interests and habits you have developed all along the way to this period of life's fulfillment.

One habit of mind much to be desired is the willingness to accept life gracefully and without petty complaint. As our children lose their dependence upon us, they tend to cut the family ties which have meant so much to us, their parents. Again, younger and more vigorous business associates may be given preference, or take the leadership we once enjoyed. When such situations arise, the chance to develop mastery of our emotions presents itself. If we rebel fruitlessly against such circumstances now, we are on the high road to an unhappy, petulant old age.

Contentment is Earned

One can be alert to steer himself out of mental ruts by being willing to try new things or new ways of doing the old ones. Mental health depends, too, upon keeping in direct touch with human affairs. The older person, freed in part from demands of business or family, often has an opportunity to add his mite to the welfare of others through his church, fraternal group, or his neighborhiod associations, for he has both time and judgment to offer. If he gives them generously, he may find that he will be richly repaid.

What does it profit a man to gain renown or riches if he ends his days idle, lonely, and discontented? Fame and a fat purse cannot assure continued happiness. Contentment is not so cheaply bought. Instead, contentment must be earned, and oddly enough, we earn it by losing ourselves in work. Everyone, old or young, wants to be busy at something worth doing. If it is to be satisfying, this activity must do more than just keep the hands in motion, it must call for the continued improvement in the use of some special skill, or the application of some ever-widening knowledge. It should be in a field in which the skill or knowledge acquired through the years makes up for the limitations that age imposes on physical endurance.

More Leisure Hours

Many of us, as youngsters, developed an aptitude for some form of art or craft or sport, only to have our interest wane because of pressure of day-to-day living during the middle years. But as life advances, more hours of leisure may permit the enthusiasms of our earlier years to return. Now we have more time to improve skills, more opportunity to read and plan, and more patience for reflection, and more ability for self-criticism of our handiwork.

It is doubtful if a lasting interest in a hobby can be forced, but this does not mean that expertness and understanding need never be cultivated. Indeed, most hobbies that give enduring satisfaction are reached through a period of apprenticeship which often requires a certain amount of grit and endurance to get to the point where the enjoyment begins and the hobby is ridden in real earnest. If we wait until old age is upon us before we begin to interest ourselves in a hobby, we may find that the apprentice period requires more energy than we have retained.

A hobby should earn for the follower some very substantial rewards in lasting satisfaction. It should

(Continued on page 30)

REORGANIZATION OF THE NCARP

Shown above discussing the NCARP's "new look" are (l. to r.), Roberta E. Lytle, Social Work Consultant; Dr. Donald Macdonald, ARP Medical Director; Dr. Eugene Hargrove, Commissioner of Mental Health, N. C. Hospitals Board of Control; and Dr. Norbert L. Kelly, Associate Director of the Program.

THE N. C. Alcoholic Rehabilitation Program is being reorganized to provide more effective care and treatment of alcoholic patients, according to Dr. Eugene Hargrove, North Carolina's Commissioner of Mental Health.

The reorganization plan provides for a co-directorship of the Program, shared by an educator and a psychiatrist; complete separation of the Alcoholic Rehabilitation Center at Butner from the business operations of the John Umstead Hospital for the mentally ill; increased professional standards for clinical personnel; a full-time Social Service Department at the Butner Rehabilitation Center; stepped-up emphasis on research into the complexities of the alcoholism problem.

Behind the plan rests the firm and skillful administrative hand of Commissioner Hargrove with the full backing of the N. C. Hospitals Board of Control. The Alcoholic Rehabilitation Program will continue to operate under the jurisdiction of the Hospitals Board, where it has been since its inception in 1949.

Under the new set-up, Dr. Norbert L. Kelly, well known figure in the

field of alcoholism education, serves as Associate Director in charge of the educational and public relations phase of the Program. Dr. Kelly and his staff are located in Raleigh at 216 N. Dawson Street.

Recently appointed to fill the post of ARP Medical Director is Dr. Donald E. Macdonald, who will guide the treatment program from his offices at the Rehabilitation Center, Butner, N. C.

The two men will share responsibility for further development of community out-patient alcoholic clinics and other local resources, and will work together in coordinating research.

Dr. Kelly is a trained sociologist, holder of the Ph.D. degree from the University of North Carolina. He gained nationwide recognition as a leader in alcoholism education while serving as ARP Educational Director, a position he held from 1952 until 1958, when he was elevated to Acting Executive Director following the death of the late S. Kinion Proctor.

Of the Program's educational activities, Dr. Kelly says, "Our ultimate objectives in education are to achieve greater public understanding of alcoholism as a treatable illness and to prevent the spread of the illness in oncoming generations."

Many Publications

Best known of the ARP's current educational services is INVENTORY, a bi-monthly journal on alcohol problems which goes free of charge to more than 17,000 voluntary subscribers throughout North Carolina, to every state in the nation and to nearly 50 foreign countries.

Under Dr. Kelly's direction, the Program also publishes a broad selection of pamphlets, reprints and booklets; conducts summer college courses on alcohol education for classroom teachers; sponsors a wide variety of public and professional institutes and forums; produces radio, television and newspaper materials for dissemination through these mass media; recruits and screens professional applicants for scholarships to the Yale University Summer School of Alcohol Studies; and furnishes speakers and visual aids to civic, church and community groups all over the State.

Dr. Donald E. Macdonald, the new NCARP Medical Director, a native of Scotland, is an American citizen and a longtime resident of North Carolina. After earning the M. D. degree at St. Andrews Medical School in Dundee, Scotland, Macdonald came to Butner where he was employed for several years on the medical staff of the John Umstead Hospital and as part-time physician at the Alcoholic Rehabilitation Center. It was here that his interest in alcoholics was sparked, through his close association with Dr. Lorant Forizs, dynamic Hungarian-born psychiatrist who formulated the original alcoholic treatment program at Butner and admitted the Rehabilitation Center's first patient. Later, after Dr. Forizs' departure, Dr. Macdonald was appointed Clinical Director for both the State Hospital and the Alcoholic Center.

Macdonald studied psychiatry at the University of North Carolina Medical School, completing his residency requirements in 1957. His further experience includes duty in a private psychiatric hospital and in a community Mental Hygiene Clinic.

Dr. Macdonald has already begun a series of progressive steps in improving the treatment program at Butner.

The Alcoholic Center, long under the administrative and fiscal control of the John Umstead Hospital, has been given its own budget along with control of all personnel matters. "Our

patients are now admitted directly to the Center," explains Dr. Macdonald, "whereas they formerly had to go first to the mental hospital in order to get to us." Admission to the Rehabilitation Center continues on a voluntary basis for a 28-day period. Full cost of treatment is $75.

Dr. Macdonald speaks with conviction in outlining other improvements he plans. "We want to build up an adequate staff of highly trained professional people here so that we can devote more time to planning with individual patients," he says. He has already employed a professionally trained vocational counselor on the staff and plans to add another full-time physician as soon as the right person can be found. Because of past shortages of qualified personnel, treatment has been largely on a mass basis, with group discussion the principal means of therapy. Group therapy will be continued in the treatment scheme, but with more tailoring to fit each patient's level of comprehension and his individual needs.

Social Service

Plans for establishing the Rehabilitation Center's first professionally trained Social Service Department are nearing fruition. Named to head this service is Miss Roberta Lytle who earned her graduate degree in Psychiatric Social Work from Smith College. Her broad experience includes a number of years of working with alcoholics and their families as Chief Social Worker in the Virginia Division of Alcohol Studies, located at Medical College of Virginia, Richmond. Since 1954 she has been with the NCARP's Raleigh staff in the position of Psychiatric Social Work Consultant.

Experience in other alcoholic treatment centers has pointed up the unique contribution that the trained social worker functioning as a respected member of the treatment team can make toward the patient's recovery. Miss Lytle describes the social worker's role this way:

"The basic tools of the social worker's profession include strict confidentiality, skilled interviewing, and a knowledge of community resources and how to employ them effectively to help the patient to build a sober, happier life following treatment. She is trained to build a warm relationship with patients, enabling them to talk freely about their life situation —drinking problem, family life, job, relations with others, general health —everything affecting the whole man. Her "social diagnosis" of the patient, when pooled with the knowledge of the psychiatrist and others on the treatment team is used to help the patient evaluate his strengths and liabilities and then to build up the positive side."

Final Phase

A final phase in the "new look" at the ARC will be a greatly increased emphasis on research. "We hope to develop a truly research-oriented treatment center," says Dr. Macdonald, "for it is only through organized study of our methods and results that we can learn how to be more effective in treating patients."

As a stimulus to research, Dr. Macdonald, Dr. Kelly and Dr. Myron G. Sandifer, Jr., Director of Research for the Hospitals Board of Control called a meeting on November 25 of all professional people in the State interested in studies on alcoholism. The response was encouraging and it is expected that within the year a number of promising research studies will be designed and launched. Even prior to the meeting, two researchers, a psychologist and a sociologist, had submitted preliminary plans for research projects on alcoholism at the Butner Center.—*G.H.A.*

Presenting—

SAM THE HALF-MAN IN INDUSTRY

Sam might be a craftsman, foreman, salesman, senior executive or one of your fellow workers. He might even be YOU! Follow Sam's slow but progressive steps to alcoholism and back again.

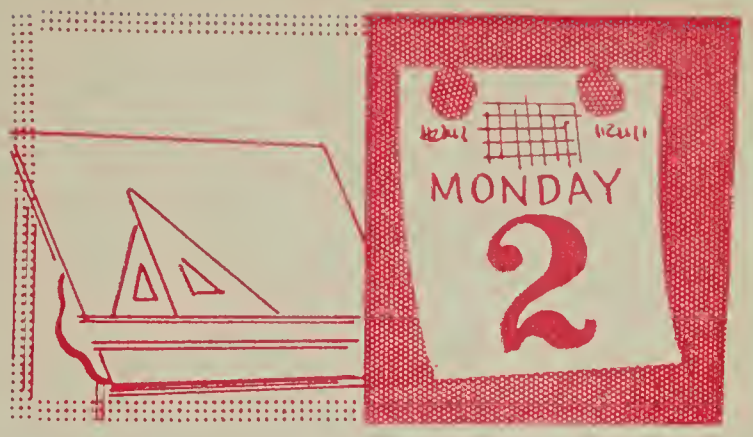
1. PROMOTION

After having been with the company for 15 years, Sam is chosen to head the "new model project." During the last five years Sam's drinking has increased, but this is not the sort of thing anyone would talk about, and, of course, it would not appear on any record.

2. CELEBRATION

To celebrate his good fortune, Sam drinks perhaps a little more than the rest of the boys, just as he has for years. One drink usually leads to another and another. His friends seem to be able to "take it or leave it." But, somehow, once Sam starts to drink, he finds it hard to stop. Drinking has become a real problem to him.

3. **MONDAY ABSENTEE**
Sometimes Sam's "evening out" with the boys leads to heavy week-end drinking. The resulting hangover makes him unable to report to work on Monday morning. Sam is absent more than twice as often as the average employee and draws three times as much in sickness payments.



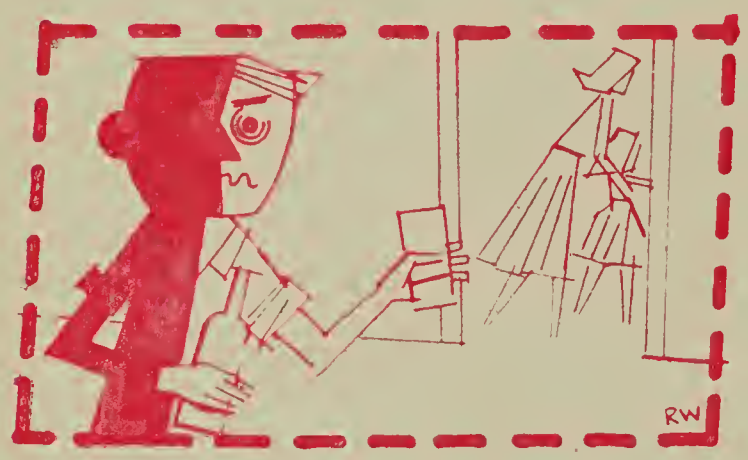
4. **BLACKOUT**
After an evening of drinking, Sam is puzzled the next morning by a blackout—a temporary loss of memory. He can recall nothing that happened the night before. Back at work, Sam finds it difficult to make accurate calculations for the new model, but he has learned how to "cover up." Neither he nor his boss admits that Sam has any problem with drinking.

5. **COVER UP**
"He's Sam the half-man," joked Tom one Tuesday. "Sam's body came to work, but his mind didn't come along. His work is all cockeyed." But good old Tom won't squawk. If he did the company would just fire Sam, fine him, or bawl him out. So Tom continues to cover Sam's absences and mistakes.

6. **LATE TO WORK**
Sam finds that he needs an "eye opener" to help start the day. Being just a little late to work becomes a habit, but the company guard does not report Sam to management. This makes it easier for everyone to ignore the situation.

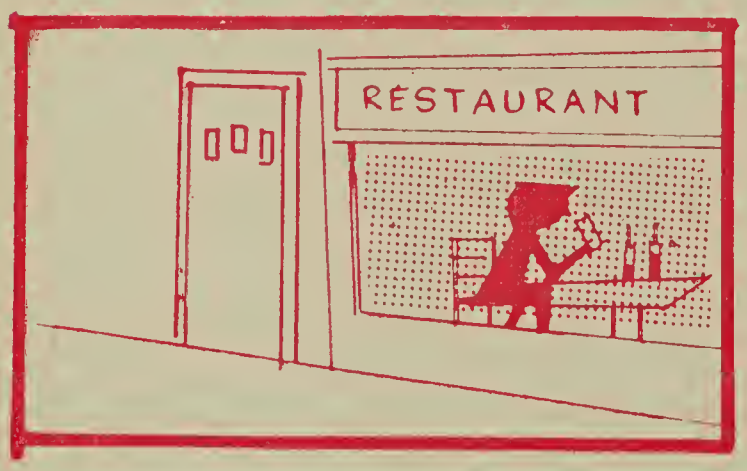
7. ALIBI

Sam develops lots of alibis for his drinking. Drinking becomes increasingly important to him. After all, his new job brings lots of responsibility; things aren't going well at home; bills are mounting up. Sam often has "one too many" after work, and Tom has to help him home.



8. DRINK ALONE

Sam begins to drink alone on week ends. His wife and children often go out to avoid unpleasant scenes with him. Sam drinks a lot and eats very little. He is nervous and has trouble sleeping. Frequent "colds" cause increasing absences from work, usually just after pay day.



9. HIDDEN PROBLEM

Often Sam is shaky and nervous during the morning work hours, but a drink with his lunch "at the place across the street" makes him feel alert and much more steady although it actually dulls his brain and nerves. Sam covers this up. He is a half-man with a hidden problem.

10. ONE OF SAM'S DAYS

Occasionally Sam has days when he just sits at his work with his tools in approximately the usual order. His thoughts are rather vague and depressing. At times he thinks of the kind of a person he might have been. The little work that he does is filled with mistakes.

11. **RESENTMENT**

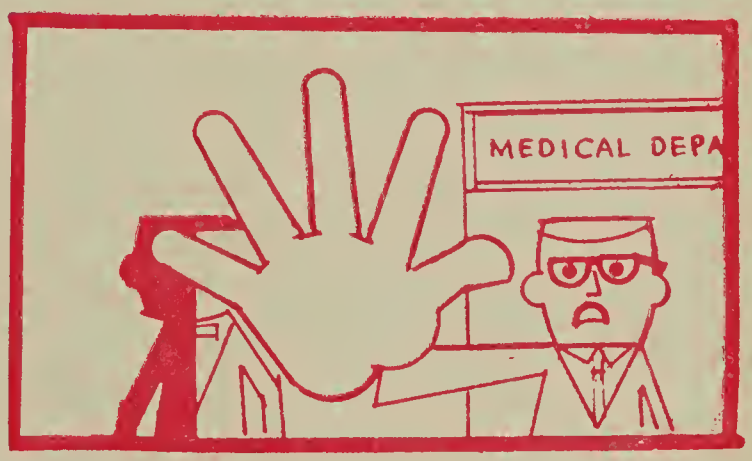
Sam shaves carelessly, and his general appearance becomes untidy. When fellow workers try to point out that he is drinking too much, Sam is resentful. Worry over the new model adds to his tension. Week-end drinking grows heavier. Mondays become increasingly difficult. Sam is a victim of alcoholism.

12. **THE BIG TEST**

The new model is complete. To the company it represents thousands of dollars. To Sam it represents his big chance. But when test time arrives, Sam is not there. Instead of facing the tension of this crisis, he goes off on a real drinking bender.

13. **DON'T FIRE SAM**

"Stop," says the company medical director. "Alcoholism is an illness and a company health problem. We need to recognize that Sam is sick. Alcoholism can be successfully treated, especially in its early stages. Everyone should know the danger signs of alcoholism and the facilities offered for treatment."



14. **FELLOW WORKERS HELP**

"By trying to cover up Sam's drinking problem, we have been unjust to him, his family and ourselves," say his fellow workers. "Instead of trying to hide Sam's trouble we should work with the medical department and help him to seek professional guidance and treatment. This calls for real teamwork by medicine, labor, and management."

15. MANAGEMENT HELPS

"We have invested a great deal of money in training Sam and others like him who are highly skilled, intelligent people. We need them," says management after assessing the extent and costs of problem drinking among employees. "Instead of firing Sam, let's offer him help and treatment."

16. COMPANY PROBLEM

With the help of the medical department, an educational and treatment program is organized at the company. A special supervisor is appointed to head the new program, which enlists the aid of all personnel at the plant and every available resource in the community to fight this illness.

17. SPECIAL TREATMENT

Sam is treated by the company's medical department and is referred for additional help to Alcoholics Anonymous, to an in-patient treatment center, or to an out-patient clinic for alcoholics. So, Sam starts a treatment program which asists him in learning how to deal with his anxieties and to abandon alcohol as an escape from them.

18. CONTINUED HELP

To solidify these gains against an illness which has taken years to develop, Sam needs the support and understanding of his family, employer, Alcoholics Anonymous, clergy, clinic, and friends. With their assistance, Sam becomes a whole man again—an asset to his community and his company.

STATE, LOCAL ALCOHOLISM PROGRAMS MEET

BY JACKIE RANSDELL

Program personnel discuss their activities, envision a closer association and regular meetings.

ON September 27 in the University community of Chapel Hill, representatives from state and local alcoholism programs met to exchange ideas and learn more about the activities of each community group represented. The sessions, which lasted for two days, were held at the Institute of Government. The agenda was flexible to allow opportunity for discussion.

Dr. Norbert L. Kelly, Associate Director of the State ARP, served as Chairman of the group which included representatives from all nine of the State's local programs on alcoholism.

Those attending the conference included Mr. John Ruggles, Reverend Martin Caldwell, and Miss Mary Logan from Southern Pines; Mrs. Olga Davis from Durham; Mrs. Anne Wall from Reidsville; Reverend Joseph Kellerman, Mr. William Hales, and Mrs. Mary Jim Whitlow from Charlotte; Mr. William J. McCord, former Education Director of S. C. Alcoholism programs; Reverend Edward Laffman from Henderson; Reverend and Mrs. R. P. Sieving from Newton; Mrs. Virginia O'Connell of Winston-Salem; and Mr. Worth Williams of Greensboro.

Others attending the conference were Mr. David Godfrey of the N. C. Prison Department; Dr. Thomas Jones, of Durham; Mr. Thomas Griffin of Goldsboro; and Dr. Donald Macdonald, Medical Director of the State ARP, together with Dr. Kelly, Mr. George H. Adams, Miss Roberta E. Lytle, and Miss Jackie McCarthy, all of the Raleigh staff.

After Dr. Kelly had presented the tentative agenda, representatives from the various programs were invited to describe the organization and various functions of their parti-

cular groups.

With the exception of the Reidsville program, which secures its funds for operation through the United Fund, and the Forsyth County organization, which derives its means of support from the County General Fund, all of the local programs on alcoholism are financed by ABC receipts. These funds help support the many activities of the various programs.

Increasing Interest

There is in evidence today an increasing interest in the problem of alcoholism as an illness that can be prevented and treated. Therefore, education of the public is one of the key functions of all of the local programs throughout the state. Acting as centers for disseminating information, the local programs distribute large amounts of literature to those individuals and groups requesting them. The programs provide speakers for civic clubs and church and school groups and act as referral services for alcoholics and their families. Counseling services for patients and families are provided by some of the programs. Several of the groups have sponsored special information weeks on alcoholism, such as the Durham Alcoholism Information Week and the Alcoholism Education Week sponsored by the Greensboro program.

Efforts to widen the scope of services which the various programs provide are being made. The Charlotte organization is at present working toward the establishment of a part-time Out-Patient Clinic, and the newest member of the local programs group, Vance County, has recently established an Information Office.

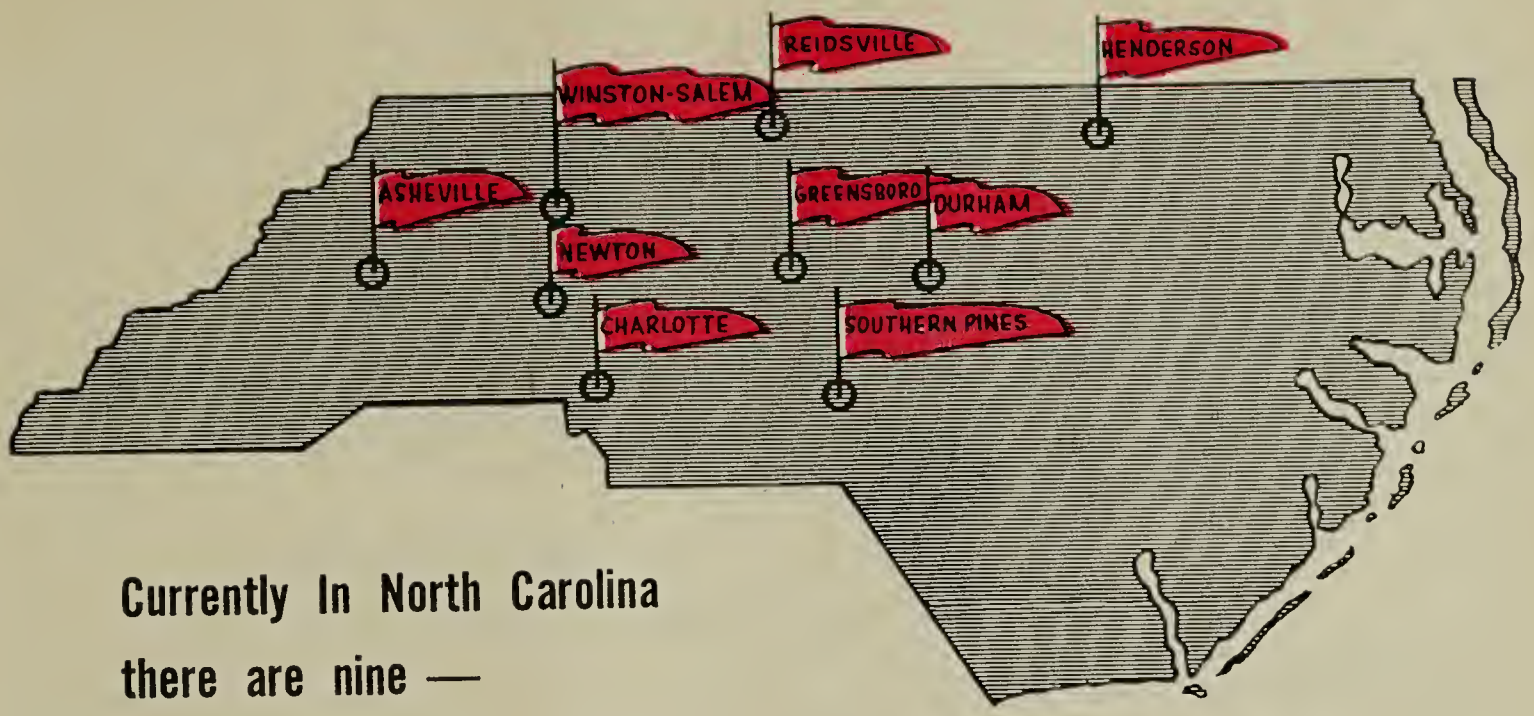
In addition to sharing with each other ideas and information about their respective local programs on alcoholism, members of the group heard Mr. David Godfrey present some facts concerning the N. C. State prisons. Much is being done toward educating and helping the inmates with respect to alcoholism, he said, and cited the Alcoholics Anonymous program as giving a large assist to members of its group.

Medical Director Present

Dr. Donald Macdonald, Medical Director of the State ARP, was on hand to talk with the group about the State Alcoholic Rehabilitation Center located at Butner, N. C. A suggestion was made by one of the members of the group that the admission procedure be slightly altered so that prospective patients might make interview appointments by telephone as well as by a written application. This change has just recently been made, and is now in effect.

The two-day meet concluded with the motion that all of the local programs be organized into a more formal, permanent group. It was suggested that Dr. Kelly appoint a committee to act on this proposal. A group is presently being organized for that purpose.

It was generally felt by all who attended the Chapel Hill conference that the meeting was helpful, and that future similar meetings should occur often. Gatherings of this type, in which individuals present can discuss their problems and air their grievances, can be most profitable and beneficial for all concerned. It is hoped that the new organization composed of all the State's local programs on alcoholism, which is in the making, will mark another step in North Carolina's progress in alcoholism education and rehabilitation.



Currently In North Carolina there are nine —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—

Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)

Educational Division, Board of Alcohol Control
West Wing, Parkway Office Building, Asheville
Margery J. Lord, M.D., Administrator

CHARLOTTE—

Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellermann, Director
William Hales, Associate Director

DURHAM—

Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Executive Secretary

GREENSBORO—

Educational Division, Alcoholic Board of Control
Greensboro
Mr. Worth Williams, Executive Secretary

Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Mr. Worth Williams, Executive Director

HENDERSON—

Vance County Program on Alcoholism
Reverend Edward Laffman
Route 2, P. O. Box 88A, Henderson

NEWTON—

Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton)

REIDSVILLE

Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SOUTHERN PINES—

Moore County Alcoholic Education Committee
Rev. Martin Caldwell, Director
P. O. Box 1098, 350 S. Ridge St.
Southern Pines

WINSTON-SALEM—

Forsyth County Program on Alcoholism
Woodland and Seventh Streets, Winston-Salem

2 DRINKS AND THE DRIVER

BY DON WHARTON

Even slight amounts of alcohol may cut driving performance 25-30 percent.

EVERYBODY knows that *heavy* drinking makes for poor, irresponsible, reckless driving. Dr. Leonard Goldberg, of Sweden's Caroline Institute, wasn't interested in that. He wanted to know about the effects on driving of light drinking—just a few beers or highballs. To find out, he tested 37 skilled and experienced drivers, most of them instructors at driving schools, men 20 to 45 years old, generally accustomed to moderate drinking.

Each man drove as fast as he could through a battery of six road tests constructed to measure a variety of driving accomplishments. The tests necessitated instant changes from one task to another, were deliberately designed to strain the driver's attention and produce some fatigue. Starters and assistants kept each driver racing through the six tests without a breathing spell, while three timers clocked him with stopwatches.

First, there was a garage test—driving out of an L-shaped space.

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Then the driver had to make the front wheel on the car's steering side knock down three white-painted blocks set in a slight curve—a test of forward steering. He had to back front and rear wheels of the steering side onto a plank 10 yards long and 7 inches wide. He had to turn the car around in a space only twice the width of the car, marked by parallel boards. He had to drive into a sand box, stop precisely in front of yellow flags, and, on a new signal, drive out of the deep sand. Finally, he had to parallel-park, without knocking over marking poles, in a space only one-third longer than the car.

Two Groups

When the drivers were clocked, they were split into two groups: one to drink, the other to serve as a control. Each driver in the drinking group was given either three or four bottles of 3.2 beer, or sufficient Swedish *brannvin* to equal three or four ounces of 90-proof whiskey — about the same as two good highballs. This wasn't enough alcohol to produce any symptoms of intoxication such as disturbance of gait or slurring of speech. Actually it created an alcohol concentration in their blood averaging only .049 percent. In the United States a concentration of not more than .05 perecent is legal proof of being sober; in most States three times that much, .15 percent, is required for a driver to be prosecuted for intoxication.

Now came the second run through the tests. In American courts you couldn't have convicted a single one of these drivers for being under the influence. Yet Dr. Goldberg reported that in many instances the impairment in their driving "was obvious." Self-confidence went up, judgment down, attention lagged. One driver, trying to back onto the 7-inch plank, missed, got mad, tried it again 15 times without changing his technique. When another driver's car slipped off the plank, he appeared not to notice it. Similarly, another driver didn't seem to know he'd knocked down some marking poles.

The drivers in the drinking group took a longer time to make their second run than their first, although they now had the advantage of practice, repetition, familiarity with all six tests, and the feel of the car. In contrast, Dr. Goldberg's control group—the drivers who did not drink between first and second runs—shortened their driving time almost 20 percent. Dr. Goldberg concluded that even a slight amount of alcohol "caused a deterioration in the driving performance of expert drivers of between 25 and 30 percent." And on the three tests most closely corresponding to actual driving a slight amount of alcohol impaired ability on the average by 41.8 percent.

These scientific findings coincide with much data from other parts of the world which generally have been ignored by both lawmakers and the great majority of drinkers. Many motorists claim they drive better after two or three drinks. Science shows this is pure nonsense—the motorist *feels* he drives better because alcohol removes his inhibitions and blunts his self-criticisms—precisely the same reasons the drinker thinks his jokes are funnier. But the belief still prevails, probably encouraged by laws defining .05 percent alcohol as "sober." Actually, the question is not whether a driver is "sober", but whether his driving ability has been impaired by drink, regardless if how little.

A sociologist experienced with alcohol problems told me that society would be better off if the term "drunken driver" had never been coined—by focusing attention on

"drunken" drivers, who are relatively rare, it whitewashed "drinking" drivers, who are almost numberless. Some years ago a study of traffic around Evanston, Illinois, showed that for every "drunken" driver on the roads there were about 30 who had been drinking. A more recent study of 17,000 rural traffic accidents in Michigan shows that about three times as many accidents were caused by drivers who "had been drinking" as by those actually "under the influence."

Even One Beer

Many States have laws acquitting drivers who don't have alcohol concentrations of .05 percent requiring additional evidence to prosecute a person when chemical tests show his alcohol concentration is between .05 percent and .15 percent. Goldberg's road-test evidence that such laws have no relation to reality was confirmed last Summer by a study in Toronto of 919 drivers involved in personal-injury accidents. The researchers dug into the details of each accident, pinning down the role of mechanical failures, road hazards, and driving errors. They concluded that alcohol became a factor in causing accidents at concentrations as low as .03 percent—which can result from one beer or cocktail.

How does alcohol do that?

1. *It slows down reactions.* "The average man after one large whisky," according to New Zealand's Road Code, "will take about 15 percent longer than usual to depress his brake or swing his wheel in an emergency."

2. *Creates false confidence.* Tests at the National Institute of Industrial Psychology in London showed that a driver after one and a half ounces of whisky drove a given course in a shorter time, but felt he had taken longer. This unconscious speed-up was confirmed by Michigan's study of 17,000 accidents. A State trooper told me that a few drinks seemed to make drivers "think they are Eddie Rickenbackers." Everyone who has been around drinkers knows that a little alcohol builds up confidence and tears down the faculty for self-criticism. New Zealand's Road Code put all this neatly: "A little alcohol has the double effect of making him drive worse and believe he is driving better."

3. *Impairs concentration, dulls judgment.* Alcohol makes drivers talk more and causes their attention to be more easily diverted.

4. *Affects vision.* A British ophthalmologist found that alcohol reduced capacity to see out of the corner of the eye and to pick up vehicles coming from side roads or pedestrians stepping off curbs. In Sweden, Goldberg followed up his road tests with laboratory tests which showed that after moderate drinking there was a 32 percent deterioration in vision. "Alcohol has the same effect on vision," he concluded, "as driving with sun glasses in twilight or darkness; a stronger illumination is needed for distinguishing objects and dimly lit objects will not be distinguished at all; when a person is dazzled by a sharp light, it takes a longer time before he can see clearly again."

What are we going to do about this fresh evidence, so widely corroborated that it seems reasonable proof that even slight amounts of alcohol seriously impair our driving ability? The problem can't be solved simply by writing new laws, for we are not even enforcing the old ones aimed at drunken driving. Neither can it be solved by neat little slogans such as "If you drive, don't drink. If you drink, don't drive." For one thing, such exhortations don't square with reality—obviously, it is all right to drive after drinking if the alcohol

has disappeared from your system. So the scientist asks "how long" after drinking "how much." Dr. Leon Greenberg, director of Yale's Center of Alcohol Studies, says that to be sure of avoiding impairment one must wait half an hour after one drink (highball, cocktail, bottle of beer), two hours after two drinks, four hours after three, six hours after four, eight hours after five. But drinkers, whether in a bar or a friend's living room, cannot wait for hours after the last drink.

There are millions of us, reasonable and intelligent people, whose normal life includes some drinking outside our own homes. What can such people do in a society built around the auto? We respect the new evidence but many of us, on being invited out for a few drinks, will neither abstain nor wait three or four hours before starting home—just as many extremely careful drivers do not conform to each and every speed limit.

If you fit into this group, then here are some of the things you can do:

1. Familiarize yourself with alcohol's effect on driving. By recognizing that alcohol produces a tendency to faster driving, you can hold your speed down. By realizing that it normally produces false confidence, you can guard against taking chances. You can't lessen alcohol's impairment of vision or slowing of your reactions, but you can consciously try to avoid situations in which quick reactions are imperative. Alcohol makes it harder to concentrate; when you're the driver, withdraw from the conversation; when you're a passenger, don't talk to the driver. Save the arguments and vivacious talk until you are home.

2. Use your intelligence in prespotting hazards. Obviously, driving on heavy-traffic highways or over long distances after a couple of drinks is quite different from driving a few blocks over quiet streets or a few miles on country roads. Make it a rule never to drive on a main highway, or in tough traffic, or for long distances, unless there's an interval of roughly an hour for every drink you've had. If that means doing without the drinks, do without them.

3. Don't stop for a quick one on your drive home from work. This is the worst time to mix drinking and driving—you're tired, your stomach is empty, hence alcohol has more impact. There are authentic cases of accidents caused by one drink.

4. Don't encourage guests who are driving home to have "one for the road." The man who says, "No, I've got to drive,' is respected in Scandinavia, but gets little sympathy in America. More often he's met with a laugh or some cliche such as "A bird can't fly on one wing." By example, we can all help change this.

5. For special occasions involving drinking and unavoidable traffic hazards, arrange to go home by cab.

We cannot completely solve the problem of drinking drivers. But we can and must adopt a realistic attitude toward a real menace.

IN the year 1958, some 16% of all drivers involved in traffic accidents in North Carolina had been drinking. Three hundred-two of the 6,459 drinking drivers were involved in fatal accidents.

—N. C. Dept. of Motor Vehicles
Driver Education & Accident Records Division

ALCOHOLISM

By R. MARGARET CORK, M.S.W.

TO most probation officers the alcoholic is readily recognizable, but how well do you really know him? On the understanding that through selection the severely damaged or deteriorated are not put on probation, you would, I suspect, see him as the likeable, friendly, imaginative, often intelligent and basically capable person who at the same time can be the most difficult, frustrating person on your caseload, and the one with whom you experience the most failure.

When I ask how well you really know him, I do not mean how does he appear to you, but rather to what extent do you know and understand his defensiveness, his hostility, his basic insecurity (even though well hidden), and, above all, his excessive dependency? Are you able, emotionally, to accept his need to distort the truth, break promises, act impulsively, be easily frustrated, and test you so frequently?

Depending on your background and your life experiences, you will probably have grown up with some conflict and misconceptions and prejudices around the use of alcohol. By the time you begin to work with alcoholics, it is of primary importance that you have worked through some of these, and have made a decision as well about the place of alcohol in

AND PROBATION

The probation officer can offer support to the alcoholic if he understands the illness.

From FEDERAL PROBATION, September 1957. Reprinted by permission.

your life. This is not to say that a person has to be a teetotaler or a drinker in order to help an alcoholic, but rather that you must have come to grips with the meaning of alcohol in your own life.

If you have been able to lose some of your prejudices and have comfortably resolved your conflict around whether to drink or not to drink, you will be more able to be objective about other people's use of alcohol. If you have not, you will almost inevitably bring to your relationship with an alcoholic a variety of subjective attitudes and reactions which will get in the way of your efforts to help him. You may, for instance, consciously or otherwise, consider him stupid or weak-willed since he cannot drink as you do, or, if you are a nondrinker, you may be punitive or moralizing. You may find it relatively easy to help the alcoholic when he is sober, but when he is drinking you may react with feelings of disgust and anxiety which may cause you to hit out or to punish him by withdrawal of yourself or your understanding. While you cannot condone the excessive drinking, your dislike of it and the consequent behaviour may cause you to feel dislike for the person you are trying to help. You may, on the other hand, have difficulty in seeing the alcoholic as a sick person unless he is drinking. You will be able to empathize and help him then, but once he is over his bender, you will tend to say or imply that he must stand on his own feet. In these and many other ways, your negative reactions and feelings will be quickly sensed by the alcoholic, and weeks or months of successful treatment may be undone almost overnight.

This, then, leads us to consider the second most difficult aspect of the helping relationship, namely, the alcoholic as a dependent person. In looking at this factor of dependency, it is important to recall that all of us must grow from complete dependency as an infant to a balance of dependency and independency if we are to mature. Growth varies with the quality of love, the consistent nurturing we receive from our parents or parent substitutes. Too much love, love that is overindulgent, is just as prohibitive to healthy growth as too little. Many alcoholics have suffered in relative degree from one extreme or another, and so have been arrested in their emotional growth; others have regressed to a state of immaturity (through their drinking) but in both cases there are very real dependency needs.

What happens to dependent people (child or immature adult) when their

dependency needs are not met? They become anxious, frightened, insecure. They have a tendency to give up easily and to deny responsibility. In the alcoholic we see dependency manifested in many different and individual ways. It is often seen in his denial of need for help; in his lack of trust or the belittling of dependency in others, in his overreaction to authority, in his overtalkativeness, in his overdemandingness, in his confused concept of his own worth (too great or too little), in the fact that dominant emotions are destructive rather than constructive, in his need to blame others for his problems, in his sexual conflict, his inability to break physically or emotionally with his parents, and, finally, in his inability to face reality.

Degree of Maturity

What does all this mean in terms of attitudes and your ability to work with an alcoholic? It means you must have achieved a degree of maturity yourselves (or be consciously aware of where you are in your growth toward independence) so that you may recognize the many expressions of dependence and cope comfortably with the dependency of others. You may, according to your own needs, overindulge him or minimize his needs; you may do too much or too little for him; you may expect him to give case histories, promises, good behaviour, in order to get your love and understanding; you may react negatively to playing a good father role to another adult and refuse him any dependency, or cut it off too quickly, or you may find it ego-satisfying to encourage his dependency. In either case, you deny him the chance to grow.

So far, we have stressed the importance of knowing the alcoholic as well as ourselves in this business of rehabilitating the alcoholic. At this point I would like to consider some of the ways and means of helping. First of all, there must be care in selecting those most likely to use help. While screening for probation is accepted procedure, it would seem to be doubly important in selecting alcoholics. One excessively disturbed or poorly selected alcoholic may readily upset or disturb the balance of a probation officer's work with other probationers. Most alcoholics, unless they are already fairly closely related to a clinic or to A.A., and can be readily referred back, will demand and need more of the probation officer's time and energy than most other probationers. Therefore, in the interests of all, the number of alcoholics who need direct help from the probation officer should be limited to a realistic number in relation to his total caseload.

Screening an alcoholic for probation means testing his story, his his-

RESEARCH FINDINGS?

"I've made experiments about intoxication. First I drank whiskey and water, and got drunk. Then I drank gin and water, and got drunk. Then I drank brandy and water, and got drunk. My conclusion is that, since no matter with what I mix water I get drunk, water is the most intoxicating beverage."

—from American Journal of Psychotherapy

tory, his concept of self, with certain reality factors in his past and his immediate present. A weighting in any particular direction should not necessarily discredit him for probation, but should serve to make treatment plans and goals more individual and more realistic for probationer and probation officer.

On the quality of the relationship between the probation officer and the probationer rests much of the potential for treatment. As indicated earlier, no truly helpful relationship is likely to be established if there is, on the part of the probation officer, too great an inability to control and handle his attitudes and feelings around the use of alcohol or around the excessively dependent nature of the alcoholic. It must be remembered, also, that a realationship implies a two-way process and unless he is able, or ready, to relate, and you are able to bring certain essential qualities to the relationship, the experience will likely prove too frustrating and too discouraging for both alcoholic and probation officer.

What are some of the factors which the probation officer must bring to the relationship? It is important to remember that this may be the first time the alcoholic has been able to let himself trust, or begin to trust, another adult. The immature person, like the child, needs to see and to feel some of the steady, consistent, warm, loving qualities that the young child receives from its mother, and without which it cannot grow emotionally. While in no sense should we treat the alcoholic as a child, he must, like the child, be understood and accepted as an emotionally immature person, with an expectation for growth, dependent on or limited by where he is emotionally and what there is to build on, when you first meet him. At the same time, real recognition must be given to the remnants of maturity or the more adult parts of him.

This sense of caring may be spelt out in almost everything you do, the way you talk with him, your readiness to give before you get, to help do things for himself as much as possible rather than doing for him, though at certain stages a sharing of responsibility is important. It is felt in the way you impose limits which may protect as well as lead toward self-discipline. It is seen in your ability to accept without too great threat to self, the constant testing, the hostility, the relapses and the frequent failures. It is felt in your ability to be firm but flexible. It is a way of caring which allows you to go on liking him in spite of his behaviour, to let him feel the liking and yet objectively and factually to help him face reality.

Integrity and Security

Such a realtionship with the usually irresponsible, often defiant, impulsive person is far from easy. It demands a high degree of integrity and inner security on the part of the probation officer. It calls for infinite patience and a constant awareness of one's own feelings, so that they will not get in the way of what you are trying to do. To know and to feel his suffering, his fears, his loneliness, his discouragement, and yet not overidentify with these or be impatient with him because he does not do the obvious or so-called normal thing to get rid of these feelings. This does not imply that at times it will not be appropriate to show feelings of concern, disappointment, even anger, so long as these are not directed against the alcoholic nor used as an outlet for your own needs.

Important to your relationship with an alcoholic is the everconstant awareness that he is not only having to learn or take on new ways of cop-

ing with life, but he is having to give up many relatively satisfying or protective attitudes and ways of behaving. Like many people who are not alcoholics, he has a strong resistance to change. When that change means giving up the known for the unknown, giving up the only means of escape from pain and hurt, it is infinitely harder and more frightening. The alcoholic can only begin to face the fear and begin to make the effort to change if, and as, someone is able to support him in it by constant, consistent understanding of what he is going through, and believe in his ability to achieve the change. The challenge to change must be tempered with warmth, reasonable and appropriate praise, and repetitious, realistic reassurance. Your support means that you may have to give him more time than other probationers, though for his sake and theirs there must be limits put on it. It means you will have to be more accessible. Often he cannot wait, particularly in the initial stages, from one weekly interview to another. Be less formal. Have fewer across-the-desk interviews. Involve him as much as possible in any plans, and never plan behind his back, even if you have to take steps on his behalf which he is not ready or able to take on his own.

All this may sound very well, idealistically or therapeutically, but what does it mean in a practical sense? Where does it leave you as a probation officer with a particular role to fill? While you are helping the alcoholic face reality, are you losing sight of what is realistic for you? Obviously your role cannot, nor should it be, one of intensive therapy (though it will be therapeutic), nor of being all things to him. Your role should not be one of helping him to gain insight (though some may come in the helping process), but rather one of helping him to face and adjust to his real life situation, helping him to function more adequately within the limits of his personality. At no time should the probation officer lose sight of the limits of probation, of his responsibility to the courts and the community, and he must constantly interpret these to the person he is trying to help. At the same time, your goal should be more than just keeping him sober or out of trouble while he is on probation. It should aim to fulfill the terms of probation as well as making a start on his adjustment to a more socially acceptable way of life.

It is evident from all that has been said so far that the probation officer has a particular job to do, and that there are certain ways and means of doing it that will be more effective in helping the alcoholic to be rehabilitated. It would seem obvious, then, that there are many parts of the job

ONE of society's most tragic errors, as you know, is treating alcoholism as a penal problem rather than as a health and social problem. Under this erroneous thinking, compounded of ignorance, indifference and inhumanity, an endless column of human beings in need of decent care and highly specialized treatment passes through our well-named common jails, convicted of drunkenness, vagrancy, disorderly conduct, and similar offenses.

—Austin H. MacCormick, Professor of Criminology
University of California

that cannot be done by the probation officer alone. Because the alcoholic has many problems and because these affect many or all parts of his being, he is going to need help from a variety of people and sources. Your ability to share in his rehabilitation and to help him use other community resources may make a very real difference, not only to his period of probation but also to his ongoing adjustment afterwards. It should be done as part of your relationship with him, not as something separate or that follows on where you leave off, or when he finishes his probation. If he is not ready to start on his basic problem as you first know him, do not try to push or pull him to a treatment centre or to A.A., but try to help him start, wherever he is best able, on some of his other problems. This does not mean that his alcoholism can be ignored or that it does not eventually have to be faced, but he may need to test you or learn to trust you a bit before he can face bringing his deeper problem out into the open. Let him know that you know he has a drinking problem, not by labeling him an alcoholic or not accepting his denial of being one, but rather by helping him to accept that his drinking is seriously affecting various aspects of his life, and that you are ready, whenever he is, to help him do something about this.

Interrelationships

Using other service professions in the community to help you rehabilitate the alcoholic calls for more than a theoretical acceptance of the idea. It calls for a recognition of your own personal and professional limits and a freedom from that possessiveness expressed so often by the term "my patient, my client," and from that intolerance of the quality of help offered by other groups or individuals, particularly if they have more or less training or different training than your own. Just as the clinic team shares the responsibility and each member brings particular skills to the helping process, so can the probation officer, in relative degree, work with social workers, clergy, nurses, physicians, lawyers, employers, and A.A. and treatment centres. This calls for a real knowledge of the services available, not just the places or institutions to which an alcoholic may be referred, but the attitudes and feelings and the degree of acceptance with which he is likely to be met. While it will obviously be more helpful and the alcoholic will be able to use the service more readily if everyone trying to help him understands his problem and has a positive attitude, nonetheless that isn't always possible. If the professional services in your community are limited, it is inevitable that the alcoholic will have to meet some of this negative feeling. He can often handle it if you prepare him beforehand, if you let him choose whether and when he feels ready to be referred, if you let him know you know that it is not easy but you believe he has the ability to see it through. Get his permission to talk over his problems with the person he is being referred to, and share with him the plans which you may have worked out on his behalf. Just as you have become able to accept and interpret relapses in his sobriety so must you accept and be able to interpret to these other services his resistance or failure to readily use the help they may be ready to give.

This paper would not be complete without a word about the wives of alcoholics. If you are like many, you will want to enlist them on your side to help you with the alcoholic. By and large, I would say very little of a permanent nature is accomplished

by this. Not only does the alcoholic feel and resent their being "on your side," but the wives, in particular, resent, consciously or otherwise, being called upon to help their husbands when they have such great unmet needs of their own. By this I do not mean that you should ignore her, nor that some interpretation of alcoholism is not valid, but that the best way of having her truly help the alcoholic is to recognize her need and try to get her to some social agency, Alanon group, or treatment centre where she may begin to get help with her own suffering and her own conflicts, which she either brought to the marriage or developed as a result of many years of living with an alcoholic. If—and only if—she can find and use help for herself will she be realistically a source of help to her alcoholic husband.

In spite of the fact that much of what has been said in this paper appears to be generalizations, it is not meant to be taken as such. I cannot stress too strongly the need to see the alcoholic and to work with him as an individual—a sick individual, yes, but still an individual with the individual's right to your respect as a human being, the right to make his own decisions and to find a useful and satisfying place in our society.

Making The Most Of Maturity

(Continued from page 8)

prove to be a profitable venture in contentment, and if it also produces some monetary return, as often it does, that is certainly not to be set down against the hobby. However, financial gain must always be secondary to the main benefit—that of earning an absorbing, continuing interest in living.

Perhaps the greatest benefit a hobby can offer to a person past middle age, is that it takes him out of himself and into contact with other men and women of similar interests who talk his language, and it offers that wholesome competition which adds to the zest of living. We need the companionship and the challenge of our equals.

Economic security, a healthy body, a serene mind, and something worthwhile to do, these are signposts that mark the road to contentment.

BY AN ANONYMOUS ALCOHOLIC

● *"It has no monetary value, but the wealth of Croesus cannot buy it."*

YESTERDAY I received a chip. It was given to mark a milestone along my journey with AA. Now just what does this chip mean to me? It has no monetary value. It cannot be exchanged for food, clothes or drink. Yet, I was told to carry this Chip with me constantly, that it has an important place in my life. I was told that when temptation asserted its ugly head, that I might reach in my pocket and be reminded of all that this Chip stands for and that this reminder might keep me in that path that AA had pointed out as available to me. So, tonight, away from AA friends, in the quiet of my own home, "the meaning of this Chip" is a question that I want to answer, at least in part.

First, it means to me that a person who was a prisoner of alcohol, whose every waking moment was consciously or unconsciously centered on the need for a drink, whose times for "coming in and going out" were fixed by the location of a bottle, has found freedom. Before, nothing that could possibly be avoided was allowed to interfere with the schedule of my drinking. I might feel an impulse to do some small act of kindness; I might feel a duty to call on a sick friend, or attend a meeting of some religious significance, even have a desire to spend a quiet evening among socially-minded friends who did not require a "shot" to keep them livable. The impulse, the duty, the desire to do anything but drink was subordinated to the compulsion to drink. So, gradually the thought of doing the normal things faded out of my mind, while the compulsion to drink and live in an unnatural world, a world of false strength and energy, completely controlled me.

My Chip reminds me that the condition described is gone. My Chip means to me that that world of "make-believe" is like a foreign shore upon which I journeyed for a time, but now I am back home where I can see and feel the things of my

home-land, undistorted by drink and hallucinations.

My Chip means to me that so long as I follow the program of AA, I can walk among my fellowmen undaunted and unafraid. My respect for them, as well as my self-respect, restored, my courage real and not unnaturally boosted by a false strength of alcohol.

My Chip means to me that I can walk into my own home and there be greeted by my loved ones gladly and unreservedly; that the light in the eyes of the one person whose good opinion I crave above that of any other living person, is not marred by fright or by a question in her mind as to whether I am going to act normally. There is a glad welcome instead of a lurking fear of a condition created by drink. There are plans for our own and our family's future to be discussed instead of suggestions and pleading to give even temporary relief from a condition due to alcohol.

My Chip means that so long as I follow the AA program, I will wake up each morning with joy in my heart and thanks for a new day unbeclouded by a hang-over from yesterday, a morning that lets me clearly remember what I said and did the day before, the obligations I assumed and the promises I made with the feeling that I can and will keep them.

My Chip means to me that physically I am a new man. The aches and pains which so beset me throughout the years of drinking but which I never attributed to drink, have miraculously passed away.

My Chip means to me that daily as I walk the street, I am greeted by friends I never realized existed before. Many of them knew little or nothing of my personal habits, some knew more than I dreamed they knew, but each now assures me of a change for the better in my appearance, attitude and my companionship.

My Chip means to me that I have found a host of friends in AA who have faced the same problem that was mine. They have an understanding that few "outsiders" can have or appreciate. They have an understanding that never blames or criticizes, an understanding that is an out-stretched hand to keep me on the path of sobriety, or to help me back on this path should I stray from it.

God Is Near

Supremely, my Chip means to me that God, as I understand Him, is my constant companion, that I have only to call and He will answer; that Step Three in our program is not just a theory, but a practical step in every situation. Step Three says: "Turn our will and our lives over to God as we understand Him." Truly the members of AA can say without reservation: "God is my refuge and strength, a very present help in trouble."

My Chip means everything to me: friends, physical health, respect, love of family, love by my family, love of God, and assurance of His love for me.

Beyond all this is one other thought: Should I forget his benefits, should disaster overtake me, I have but to again sincerely accept the fact that I am powerless over alcohol, turn my will and my life over to God, and the door is opened again and again for me to enter, and a loving God will welcome me back into the fold . . . Yes, my Chip has no monetary value but the wealth of a Croesus cannot buy it. (Reprinted from CHIPS FROM NEW BERN)

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

JAN.-FEB., 1960

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

"... Wisdom"

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Social Aspects Of Alcoholism

The Alcoholic: A Victim Of Attitudes

$1,100,000 Grant For Alcoholism Research

The Role Of Parents In Alcohol Problems

Counseling The Alcoholic

News From 'Round The World

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, social worker, a recreation director, an occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.

3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday

Patients must be sober upon admission, and in good physicial condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

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Psychiatric Social Work Consultant

INVENTORY

VOLUME IX NUMBER 5

JANUARY-FEBRUARY, 1960

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices 216 N. Dawson St., Raleigh, North Carolina.

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Assistant Editor

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Circulation Manager

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Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

NEW HAVEN, CONN.: The dates of July 31-August 6, 1960 have been set as the time for the 26th International Congress Against Alcoholism to be held in Stockholm, Sweden, under the patronage of King Gustof VI Adolf.

RALEIGH: There have been several timely articles on the subject of mental health published in a number of our national magazines. We would like to call attention to the following articles: "What You Should Know About the Drinking Problem" by Dr. C. Anthony D'Alonzo in the August 24, 1959 issue of **U.S. News and World Report;** "Hope For Better and Cheaper Mental Health" by James C. G. Coniff in the October, 1959 issue of **Today's Health; and** "What You Should Know About Mental Health" by Dr. George S. Stevenson, in the December, 1959 issue of **Today's Health.**

NEW YORK: Nearly half a million pieces of literature on alcoholism were distributed by local committees affiliated with the National Council of Alcoholism during 1958. Committees which reported are in 15 continental states and Hawaii.

HARTFORD, CONN.: The **Christian Science Monitor** reports that the Traveler's Insurance Company has announced a plan for lower insurance costs for careful drivers. A household that has gone three years without a chargeable accident and without a conviction for a moving traffic violation is allowed a twenty per cent discount on the basic policy rate. If there is only one such violation, the discount is ten per cent. A chargeable accident or two moving violations would continue the regular rate. Several accidents, moving violations, or a conviction for drunk driving, move the percentages to the other side of the ledger. Based on a point system, the careless driver would pay from 20 to 100 per cent above the basic rate. Discounts up to 30 per cent would be allowed on the basis of a favorable five-year record.

AVON PARK, FLORIDA: The Florida State Alcoholic Rehabilitation Program "Reporter" quotes U. S. Secretary of Health, Education and Welfare Arthur S. Flemming as saying that problem drinkers in the United States are increasing at the rate of 200,000 a year.

TORONTO, CANADA: The TORONTO DAILY STAR reports that the DuPont Corporation has treated 900 problem drinkers under its program. The cost per rehabilitation is less than $100 and the success of effective treatment runs 66 per cent.

RALEIGH: In the December, 1959 issue of COSMOPOLITAN magazine, there is an article entitled "The Alcoholic Marriage" by Gerald Walker. The story concerns studies made by Dr. William J. Browne of the Department of Psychiatry of the University of Pittsburgh, and our good friend Dr. John A. Ewing, Associate Professor of Psychiatry at the University of North Carolina School of Medicine. These studies were originally presented at the annual meeting of the American Psychiatric Association in Philadelphia last Spring.

ONTARIO, CANADA: West Germans are increasing their consumption of non-alcoholic drinks at a formidable rate. The annual consumption per capita has risen from about 16 pints before the war to about 45 pints today. Only 15 per cent more beer is drunk than before the war and about 20 per cent more wine. The consumption of ordinary drinking water continues to fall. Following the war, authorities dosed the drinking water of West Germany liberally with chlorine as a guard against epidemics.

NEW YORK: Dr. E. M. Jellinek of Yale University and "Bill", one of the founders of Alcoholics Anonymous, were the recipients of National Council on Alcoholism gold key awards. The presentations were made by Marty Mann, Executive Director of the NCA, at its Fifteenth Anniversary Dinner held at the Waldorf-Astoria.

AVON PARK, FLORIDA: The University of Florida is the recipient of a $12,500 grant for use by the department of psychiatry of the medical school to provide special treatment for alcoholic patients in the school's hospital. The grant was made by the Florida State Alcoholic Rehabilitation Program, which also renewed a grant of $12,500 to the State Department of Education to continue its development of alcohol education in the public schools of Florida.

ONTARIO, CANADA: The Bureau of Statistics has made a survey of family expenditures in major Canadian cities. The survey made every two years is based on the spending habits of 1,088 representative families during 1957. Torontonians, for example, spent almost four times as much on smoking and drinking as on education and reading combined. Running automobiles cost more than new clothing. Smokes and alcoholic drinks, for the 213 sample families in the Toronto area, cost $203 compared with $28 for education and $35 for reading.

Much Help

May I take this opportunity to thank you for the privilege of receiving your excellent publication. As chairman of the New Castle Committee on Alcoholic Education, I use it each month at our meetings, and we have received much help from knowing what North Carolina is doing.

Mrs. Ruth W. Morris
New Castle, Pa.

Excellent Magazine

Please put me on the mailing list for INVENTORY. I am office secretary and educational director of the Marshville Baptist Church. It is an excellent magazine, especially for those who counsel and work with alcoholics and their families.

Mrs. J. J. Griffin
Marshville, N. C.

Nurse Writes

If possible I would like to be put on your mailing list for INVENTORY, beginning with your last issue. I am a psychiatric nurse and fairly frequently receive questions about someone who has a problem about alcoholism.

Miss M. Audrey Kachelski
Chapel Hill, N. C.

Assistance Appreciated

Please enter my name on your mailing list for those who receive INVENTORY. I am the associate pastor and educational director for the Union Grove Baptist Church of Kernersville. I am very much interested in ministering to those who find themselves victims of drugs or alcohol. Please send me any other free material and literature that you have on hand plus information regarding filmstrips, etc. At present I am also a student at Southeastern Baptist Seminary and have been introduced to your services through a course in Religious Education. I appreciate the work that you are doing and the assistance you offer to pastors and others who are vitally concerned about the problems of mankind.

Mr. John Baxley
Winston-Salem, N. C.

Counselor Writes

I would greatly appreciate being on the mailing list to receive your very excellent publication, INVENTORY. Your magazine will be of great help to me not only in my work as an employment counselor, but also as secretary of one of the Milwaukee groups of Alcoholics Anonymous.

Anonymous
Milwaukee, Wisconsin

Helpful to Church Worker

I have recently read an issue of your bi-monthly journal "Inventory." I would appreciate it very much if you would place my name on your mailing list to receive future issues of this publication, as I feel that it would be very helpful to me in various phases of church work in which I participate.

Mrs. Edna M. Thigpen
Mount Olive, N. C.

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

By REV. MOUNIR SA'ADAH

What things can be changed and what things are unalterable? True wisdom will supply the answer.

THE Serenity Prayer: "God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference," has become so much a part of the AA ritual that an examination of its basic assumptions can be helpful. This article is intended to examine two key phrases in the prayer: first, the things we cannot change; and second, the things we can change.

Then the question that comes to the mind is: Why change? The answer to this lies in the fact that "man is a freak of the universe"; he is not at home in the world and never has been. Rousseau's "noble savage" is a myth, he is a figment of Rousseau's romantic mind. Left in the state of nature and at its mercy, man will either be destroyed within a short space of time or will return to savagery. His survival and his progress depend altogether on his willingness and ability to effect changes.

And yet man finds himself in a situation where there are a multitude of things he cannot change. In his ignorance of this fact he often expends his energies tackling those things he cannot change and thus rendering his existence more precarious, and consigning himself to ultimate failure and destruction. This makes the knowledge of what he can change and what he cannot change imperative. It is a problem of survival.

What are the things that we cannot change? First, we cannot change the fact that we are human beings. Try as we may, we cannot become horses or dogs or trees or angels. We are human.

What does it mean to be human? It means in the first place that we

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have self-awareness. We are conscious of our being as separate entities, distinct from all that is. The individual can call himself *I* and thus step aside from all else which is not himself. That is why man can find himself utterly lonely and also why he is capable of bridging his loneliness in the freedom of love.

To be human means also to be rational, to have the capacity of observing facts, comparing them, finding the causal relationships between them and arriving at specific conclusions that bear relevance to the facts in hand.

To be human means to be imaginative, to have the capacity to project one's self into the future and into the abstract and to be able to see with the inner eye that which is not available to the senses or is not yet part of reality. Man is a dreamer who can make his dreams come true.

No Set Course

Secondly, we cannot change the fact that each individual man has to live his life uniquely. No man's life can be identical to that of any other man. Nor is any man's life chartered for him. There is no imperative course of behavior set for any person. Unlike other animals who are compelled by instinctual impulses from which they cannot choose to deviate, man has to create himself by continuous rational action. His existence is a problem to himself and he cannot escape it. What he is and what he does are his own responsibility.

The third fact that man cannot change is that he lives in this world and no other. As a part of this world, he comes into direct relationship with nature which functions in accordance with fixed laws that he cannot change. To hope for miracles, in the sense of the suspension of natural laws for any purpose whatsoever, is to exhibit a fertile, infantile imagination that has no ground in the world of reality. One may understand these laws and use them, but one cannot alter them.

In this world, man also finds himself side by side with other human beings who are not predictable nor subject in their behavior to any fixed laws.

The fourth unalterable fact is that man is born in a body and the body dies. We may lengthen the span of life, but ultimately all men die; they must die. One must confront this fact of death and accept it before one can really cope with life adequately.

These are the absolutely unalterable facts; these are the things we cannot change: that we are human, that there is no fixed blue-print to guide our lives; that this is the only world in which we can spend the span of our lives; and that we ultimately die. These facts spread themselves over immense areas of our being. To revolt against them, to refuse to accept them, is like hitting our heads against the Himalayas to move them. We are left dizzy, insecure, and frustrated. The wise muster the capacity and the courage to see a fact, recognize it and accept it. How much misery and waste and crime could be avoided if we would face a fact and accept it when it confronts us.

What Can Change?

What then can we change?

In order to answer this question we shall examine the elements which constitute the highest aspirations of a human being. This we can do because mankind could not have gone on aspiring for these ends had he found them unrealizable. It is not in the nature of man to persist endlessly in pursuing the impossible. Man's ultimate aspirations are

three:

First, a desire for fulfillment—a meaningful organization of his energies in the realization of his distinct potentialities. Man is born into the world with infinite potentialities and a tremendous store of energies. The potentials can be arranged in a multitude of patterns, and his energies are sufficient for effecting those arrangements. Like a painter with all the spectrum of colors at his disposal, man can choose the pattern, he can formulate the ideal and apply his energies to bring it into being. This choosing the pattern for a fully meaningful life and realizing it is the first great human aspiration.

Immortality

Second is immortality. In the course of working out the pattern that his potentialities and his energies promise, man finds that the span of his life, both individually and collectively, is too short for the fullest realization. The strain of urgency enters into his life and he arranges "first things first". He makes the most of himself because of this knowledge that he must die.

But there comes a moment that is intensely and creatively lived when a life becomes aware of its own personal immortality. It is only the crude, blustering slothful life that sighs resignedly, "Vanity of vanities, all is vain." To the intense, responsible, purposeful being, hopes and promises are awakened and their fulfillment is intimated.

Third is happiness—a sense of inner serenity and total integration. This is not an aspiration that can be achieved by being pursued. It comes as a reward of the fulfilled life that has become assured of immortality.

Three Aspirations

Fulfillment, immortality, happiness: these are the highest aspirations of human beings. These also lie in the realm of personal character, which is the field that we are absolutely free to cultivate. In every other field, we are limited, in some fields we are absolutely prohibited. But in the field of character, we alone determine the drives that make us what we are. It is we alone who take the blame or reap the joy of our character. We can hide our motives from the eyes of the world, but ultimately we stand naked before ourselves; if we have done well, the reward is in the act; if we have done ill, there is no one to blame but ourselves.

God grant me the serenity to accept the fact of my humanity, of my free unchartered life, of my living in this world at this moment of history, and of my ultimate death. These I cannot change. But give me the courage to create my distinctive character, to select the drives for creative fulfillment, to taste of immortality, and to experience happiness.

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Social Aspects

OF ALCOHOLISM

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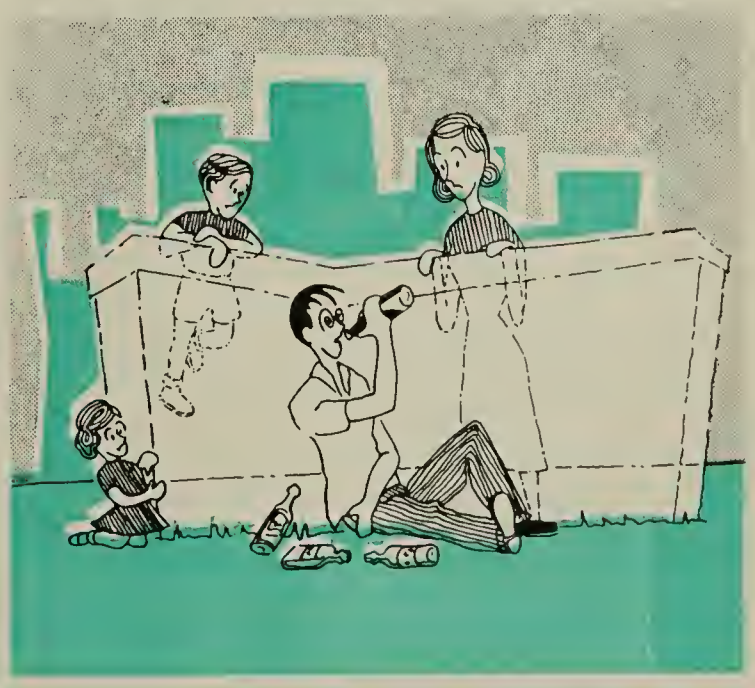
What is alcoholism? Cultural differences influence your definition.

THE general term of "alcoholism" is defined by the World Health Organization in terms of social factors. The Alcoholism Subcommittee of the Expert Committee on Mental Health, WHO, uses the term to "signify any form of drinking which in its extent goes beyond the traditional and customary 'dietary' use, or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behavior . . ."

Thus the definition is based on recurrent deviation from the accepted drinking norms that prevail in a given social setting. To this basic idea, the Committee added the concept of individual inability to stop drinking once it was begun. But the fundamental point in the definition consisted of drinking beyond socially acceptable limits.

This definition emphasizes one of the basic social characteristics of alcoholism. In the eyes of different cultural groups, it exists when a member of that grouping drinks beyond what the group regards as acceptable. For example, there are differences between the social classes in America regarding what is an alcoholic "illness." At one social class "way of life" the so-called "symptoms" of alcoholism are regarded as expected drinking behavior and persons in this social class do not readily accept the idea that anyone who displays it is "ill." Other class orientations readily accept "morning drinking," "lone" drinking, "blackouts," and other drinking behavior as clearly indicating an illness. Since one of the major problems in therapy is to get the patient to "recognize" his problem, it becomes obvious that such a recognition and ad-



mission is a near-impossible task when the individual comes from a social setting that does not regard certain drinking experiences as unacceptable.

The biochemical and physiological results of drinking alcoholic beverages are relatively uniform and predictable. The social definitions, however, of what these effects *should* mean in American society are far from consistent. A biochemical reaction within the human body does not remain purely a physical matter. For any given individual it must be interpreted, given a meaning. In American society today there is a variety of interpretations available for a person who experiences the effects of alcohol.

Variety of Opinions

The drinker can regard the effects of alcohol as a way to reduce the increase in tension that tends to develop whenever people interact with each other. It is a way to create social ease and goodwill. He can be more "relaxed and natural." Or, he can regard its results with basic guilt reactions, since he was raised to regard total abstinence as morally right. A specific religious group may have developed for him the definition that the effects of alcohol are evil. But, under social pressure, he may have imbibed some alcohol. Now, for him a guilt connotation is attached to the physical effects. Or, it is quite possible that he has learned to look upon alcohol as a way to engage in religious worship. Consequently, he gives it a ritualistic meaning. But he is more likely to define his physical reactions to alcohol as a way to manage temporarily some individual frustration. He is apt to eulogize it as one of the basic ways of adjusting to his personal sources of anxiety and tension. If he has been socialized in certain groups in American society, he will look upon it as "*the*" way to manage psychosomatic problems.

This variety of definitions creates a social ambivalence. On the one hand, alcohol has been praised and made a part of custom and tradition. On the other, it has been blamed for immorality, debauchery and crime. With the exception of sexual reactions, there are probably no physical responses subject to greater social confusion than those deriving from alcohol.

This social confusion acts as the background against which the person with a drinking problem is viewed. His compulsion to drink is regarded by some as sheer moral depravity, by others as a weakness of "will power." Others see him as suffering from an allergy. Still other observers are equally certain that he is "emotionally unstable" and takes to alcohol as a result.

Scientific Conflict

In the midst of this social confusion over alcohol and alcoholism, one basic trend is discernible. The debate about why the alcoholic is one and what to do about him is shifting from the moral arena to the scientific arena. Those who have tended to engage in moral arguments are heard from less often. Alcoholics Anonymous has demonstrated that the stigma attached to the affliction is false. Patient research has shown that the alcoholic may just as readily be the neighbor next door as the skid-row bum. The "wet" vs. "dry" battle is still with us, but not in intensity. In short, the conflict over alcohol and alcoholism has become a scientific one, demanding research rather than emotionally-charged debate.

Research from the sociological approach has focused on the role that social factors play in the actual crea-

tion of an alcoholic. There is developing a body of data to the effect that, acting alone, physical and emotional defects do not lead to alcoholism. The same defects are present in too many non-alcoholics.

Unique Illness

As an illness, alcoholism is unique in that its early symptoms are not sources of fear, but often grounds for group recognition and reward. For example, the consensus is that a sharp increase in tolerance to alcohol is an early sign of alcoholism. However, in many drinking groups this phenomenom is regarded as an ability to "hold his liquor" and to "drink 'em under the table." It is not regarded as an indication of a developing illness, but rather as a prowess conferring prestige. Other symptoms, such as blackout and loss of control are frequently regarded in a similar way.

In this manner social forces act to bring predisposition to alcoholism into an actuality. Other influences comprise ingredients conducing to alcoholism. But, in and of themselves, they do not automatically lead to beginning alcoholism. One or more social forces have to be added to them to lead to the actual use of alcohol. Otherwise, the tendencies would express themselves in some way other than alcoholism.

Channel of Expression

Recent studies indicate that the bulk of alcoholics learn, in the basic meaning of that word, to express emotional and physical deficiencies through alcoholism. In face-to-face drinking groups, predisposed persons learn first-hand by repeated usage that alcohol can act as a means of adjustment to their problems. Many drinking groups emphasize alcohol as a temporary solvent of personal troubles. The sensitive person who is attracted to such groups is essentially "taught" to lean on alcohol. He is rewarded in two ways: His sensitivity is reduced, and he is accepted by a friendly group. In both of these, alcohol is the means of reward. This "reward" experience is a social one. It acts to develop alcoholic tendencies into actual alcoholism.

We now possess some rather objective information about how alcoholism impinges on such basic institutions as the family and industry. In the family unit the alcoholic, instead of sharing emotional problems and conflicts, isolates himself from his wife and children. He builds a psychological wall about himself that, in effect, removes him from participation in family activities. Alcohol has replaced his family as the center of his life. Further destruction of the family network grows from the fantastic excuses for his drinking. In the early and middle stages of his problem, he is desperately trying to deny that he is in any way different from others. In this denial process he seizes upon any and all excuses to rationalize his drinking.

Foremost among these excuses are members of his family. Normal misunderstandings with his wife are used as an excuse to drink. The usual problems encountered in child-raising provide another easy source. Naturally this attitude and behavior damage the relationship with these family members.

Other areas of family life deteriorate as his drinking problem worsens. For example, there is a decrease in sex drive. In consequence, sexual adjustments are upset; naturally this development creates a new area of marital discord. Along with the decline in his sexual interest, the alcoholic experiences heightened jealousy regarding his wife.

Unfounded suspicions of disloyalty and fear of her ability are expressions of this jealousy.

Often the wife has married the alcoholic to meet certain emotional needs of her own. These are frequently met by pointing out to the alcoholic that she still has her "will power," i.e., can control her drinking. Implicit in the marital relationship is the ever-present question, "Why can't you drink like me?" As a consequence the wife becomes the symbol of those who, as the alcoholic puts it, "bang his ears" to use his will power and drink like others. Since this is a physical and psychological impossibility, the wife becomes a source of galling frustration. The parental relation with children is also distorted. Children often reject the alcoholic father because of the stigma and embarrassment that they feel. The net effect is to remove the alcoholic parent as a stabilizing force. Furthermore, the child of an alcoholic parent is exposed to a higher risk of becoming an alcoholic himself. This statement does not imply that alcoholism is hereditary. Rather it is based upon substantial evidence that children who live with alcoholic parents have a higher rate of alcoholism than those children who do not.

To the family the crisis of alcoholism is a situation in which they do not know how to act. A "trial and error" approach disrupts family continuity. At first the wife attempts to deny the problem. Slowly she is forced to accept it; and as she does, she typically attempts to "do something about it." She gets in touch with AA; she explores various therapies, usually of the "pill" variety. As she experiences repeated failure, she goes through a period of indecision from which she emerges with a determination to reorganize her family *without* the alcoholic husband. But even after this separation, she often takes him back since the marital relationship meets certain needs of her own.

Throughout all of this family disorganization the child lacks any clear-cut reference points as a basis for organizing his life. The family never settles into a recurrent pattern that provides a stable basis for normal living. It is constantly in flux, in a state of indecision over the alcoholic member.

Another pivotal institution, the economic life of business and industry, is directly affected by the extent and intensity of alcoholism. Certain basic facts have recently emerged that point up this situation. The early and middle-stage alcoholic continues to work. Only two out of twenty alcoholics are in the "skid-row," "lost weekend" category where their problem is so obvious that they are unemployable. Because of general unawareness of this fact, together with the "coverup" by immediate supervisors and fellow workers, employers are typically uninformed of the alcoholic's presence on their payrolls.

Generally speaking, three percent of a particular work force suffer from the problem. This varies, up and down, from company to company. But as an over-all figure it is indicative of the extent of the problem in the economic life of a community.

Problem drinkers are concentrated in the male, 35-50 age category. They are in the "breadwinner" role and the productive, mature years when an employer expects the most substantial performance from an employee. Alcoholism's impact on industry would be less emphatic if the disorder were equally spread through the various age categories and females in the population.

In contrast to this focalization by

age, alcoholic employees are *not* concentrated in certain occupational groups. They are distributed proportionately throughout the occupational structure of a community. The alcoholic employee is as apt to be a valued, long-time skilled worker as he is to be an employee with little seniority and meager skill. Recent evidence indicates that often they are long-time employees who have skills, experience, and management know-how.

It has been discovered further that the reduced work efficiency and absenteeism of the problem-drinking employee creates basic costs for his employer. Wastage, high fatigue, mistakes, rejects are all higher for the alcoholic employee. To this can be added loss of training investment, executive error, and loss of customers. And, when the alcoholic does become so chronic that he is not employable, he continues to cost industry due to the taxes required to maintain him in hospitals, clinics, jails, and workhouses.

Closely related to these social costs are the general expenditures and wage losses attributable to alcoholism. Unfortunately the best information regarding this matter comes, not from a recent, but from an old study in 1940. The expenditures for mental hospital care and treatment, for the care and treatment of bodily diseases associated with the malady, for maintenance of drunken persons in county jails, and the costs of accidents and crime amounted in that year to $357,017,000.

When the wage losses of the individual alcoholic were added, an even higher figure was reached. This amount included the loss of income by persons ill with either psychoses or physical maladies attributable to alcohol. It included also the wages unearned by inebriates in county jails, those suffering from accidents, prisoners in state and federal penal institutions, and absentees from jobs. In total amount all these losses were computed at $431,886,000 per year.

Combining these two categories of economic loss due to alcoholism gave a grand total of $778,903,000. This was a 1940 estimate. Since inflation has subsequently almost halved the value of the dollar, it seems possible to conclude that the general, overall economic loss due to alcoholism is now a billion dollars per year.

These figures do not include those intangible costs to the employer created by idle equipment, hangover inefficiency, waste, slowdown in production, executive error, irritations to consumers, and lost business. One competent observer estimated this "hidden" source of economic loss to amount to another half billion dollars.

Social factors are present in the definition and causes of alcoholism. Without the tutelage and reward of the drinking group, the predispositions to alcoholism would, in many instances, find other outlets. Also the social setting itself defines acceptable social behavior. In so doing, it is providing the basic definition of alcoholism.

If the impact of alcoholism on social institutions is considered, the social implications are clear. The family, as a basic institution, is profoundly disorganized by its presence. Economic life is not as directly affected. However, industry and business definitely feel the presence of thousands of alcoholic workers among their employees. Not only this, but general economic losses can conservatively be estimated in the billions. Unfortunately, these damages occur in a society where there is general confusion over both alcohol and alcoholism.

The Alcoholic:

A VICTIM OF ATTITUDES

By PERCY M. SESSIONS

Alcoholism is not the product of alcohol, heredity, or chemical imbalance, but of unhealthful attitudes.

A physician was called to attend a patient, an alcoholic. After assessing the condition of his patient, the physician prescribed progressively greater amounts of alcoholic beverages. Unfortunately, the patient failed to respond to this treatment, except to grow steadily worse; and the physician passed the word among his colleagues that the alcoholic patient is a very poor treatment risk.

Of course, this is only a fictitious parable, but the truth implied is valid enough. For the alcoholic, society is the physician; and society has given its patient increasing doses of that which made him sick in the first place, namely, unhealthful attitudes. Until research proves otherwise, it is probably a good bet that alcoholism is the product not of alcohol, heredity, or chemical imbalance, but rather of unhealthful attitudes. When alcolism makes its appearance in an individual, these attitudes are multiplied and intensified, so that the alcoholic has even more reason to remain ill than he had to become so in the first place.

With few if any exceptions, alcoholics have been disparaged and dominated in diverse ways—from direct, forceful domination to the most subtle and indirect innuendo, depreciation, and control. They have been

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made to feel guilty, unworthy, and inadequate. However, alcohol, with its effect of blunting one's self-critical faculties, relieves these feelings. In addition, alcohol provides these people with the capacity for defiance and gives them the strength to resist the opinions and influences of others; because the intoxicated person is not too impressed by such opinions and influences. Moreover, the alcoholic's hangover supplies the suffering he feels he must endure to get out of debt to humanity and the cosmos for allowing him to exist and to breathe the same air that is breathed by "decent" people.

Unhealthy Attitudes

An example of unhealthy attitudes is the woman who called our clinic for alcoholics and requested a supply of Antabuse, which she proposed to introduce furtively into the coffee prepared for her alcoholic son, a young man. She was aware of the danger involved in such an act but felt that she was justified in doing this anyway. When it was explained that Antabuse would not help unless her son himself desired sobriety to the extent that he would take it voluntarily, her reply was: "Oh, he'll take it! If he doesn't, I'll slap the fire out of him!"

It should be easy to guess why this woman's son has a drinking problem. Likely, it is only by getting drunk that he is ever able even momentarily to escape his mother's domination.

For centuries, people tried sporadically to treat alcoholics, but there was never any widespread and lasting success until Alcoholics Anonymous came into being. Physicians, clergymen, social workers, prohibitionists, and law enforcement officers generally failed to help the alcoholic. Why then, are members of Alcoholics Anonymous succeeding? Obviously, the answer cannot be that they are trained therapists, because few of them have any training in the helping professions. Of course, they do know what it is like from experience to be alcoholics because generally they have had ample exposure to alcoholism. Probably much more significant, however, is the fact that they are among the very few people who do not look down their noses at alcoholics. Their capacity to accept them as basically decent human beings *like themselves* greatly contributes to their success.

To those who have compassion for suffering alcoholics, it is tremendously heartening to see that a concerted effort is being made by members of different professions to understand them. True, not enough is yet known about the cause of alcoholism or about what constitutes effective treatment methods, because the concept of this illness as a treatable one is fairly new. Being a highly complicated disorder, treatment methods are necessarily diverse and extend beyond the domain of any single profession. The physician and the nurse, the psychologist and the social worker, the clergyman, and even the man on the street and the woman at the bridge table, are all concerned about the alcoholic and his treatment or rehabilitation. Each has a role to play, if only in terms of attitudes, in helping the alcoholic recover. But even the most competent of professional persons often have sharp limitations when they undertake treatment of the alcoholic.

Because of our cultural patterns of reaction, a professional person, frequently still influenced more by these patterns than by his professional training, naturally becomes somewhat annoyed with a patient whose drinking is quite obviously self-destructive—or which clearly jeopardizes the health and well be-

ing of those who are most closely associated with him and who should be the dearest to him. The professional person finds it easy and natural to develop a judgmental attitude toward the alcoholic, not realizing that when he does this his own behavior becomes very much like that of the alcoholic himself. Just as the latter makes himself miserable and unhappy by his drinking, one can make himself miserable and unhappy by indulging in condemning attitudes. Just as the alcoholic imposes difficulties on his family and others because of his apparently stubborn refusal to achieve sobriety, the professional person often joins him in imposing difficulties on the alcoholic's family and others; because, with a judgmental attitude, he can never provide the alcoholic with the sort of stimulus he needs in order to change his way of life.

People generally have adopted condemning attitudes toward the alcoholic, and these attitudes still predominate in spite of some movement away from them in recent decades. There are reasons why people cling to these attitudes. It is pointless to condemn *them* for their condemnation of alcoholics. First, it must be admitted that the alcoholic is a nuisance when he is intoxicated. No doubt his intoxication would be less frustrating if he were as disagreeable when sober as when drunk. One of the things about drunkenness that makes it offensive to us is that it often changes a mild, gentle, lovable person into a loud, boisterous, and disagreeable fiend. Since he was the one who did the drinking to make this change in himself, we tend to blame him for the act and for the consequences of his behavior. The other aspect of his behavior which frustrates and antagonizes us is the stubborn persistence with which he repeats his act of drinking.

Since time has honored the practice of holding the individual responsible for his behavior, it is understandable that we tend to condemn the alcoholic. It is understandable—but futile and unwise. We know it is useless because condemnation has been used over the centuries and very few alcoholics have made a healthy response to it. Just as they have persisted in their drinking behavior without accomplishing anything constructive by it, too many of us have persisted in our condemning behavior without accomplishing anything constructive by it.

Perhaps most of us have the experience of rather suddenly losing our resentment or condemning attitude in some specific situation, when we were provided with pertinent facts which we had previously not known. Then perhaps the alcoholic's behavior can be explained with information so far withheld from us. If this is true, it may be asked, why does the alcoholic withhold this information? Why does he not tell us the reason he is unable to stop drinking? The answer is that the alcoholic himself does not know why he cannot achieve sobriety. This is evidenced by the fact that many alcoholics share our frustration with themselves and with their inability to discontinue drinking. Many condemn themselves more bitterly than they are ever condemned by others. Therefore, we must look to some source other than the alcoholic for the needed information.

What, after all, is the nature of alcoholism? It may be defined as the repeated and compulsive use of alcoholic beverages in such a way as to result in detriment to the person and others. By this definition, then, alcoholism is self-punishing. Since it markedly shortens life, it is suicide on the installment plan. The alcoholic's self-condemnation should give

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us one clue as to why he drinks. He apparently drinks because of the suffering which he feels he must bring on himself. This being the case, what we need to do in order to help the alcoholic is help him adopt a more benevolent attitude toward himself, rather than condemn him or support his own self-condemnation. This treatment is precisely the opposite from that which is usually meted out to him. There is little wonder that he "stubbornly" persists in his behavior. We generally help him in this direction as much as we can, and the alcoholic's stubbornness is matched by our own.

Are you skeptical of the foregoing? Do you believe that the alcoholic really drinks because he is selfish and wants the pleasures of drink? What pleasures? To be sure, he does enjoy momentary relief from tension. He does escape into oblivion. But these pleasures are fleeting. The tension returns. Consciousness and self-awareness return. Anyone who really knows an alcoholic knows that the penalties he pays for drinking far outweigh any pleasures derived. How can such behavior be accounted for on the basis of selfishness?

While the persistence of alcoholism may be attributed in some measure to society's condemning attitudes toward the alcoholic, we cannot say that these cause the illness in the first place; after all, society does not condemn him as an alcoholic until he first distinguishes himself as one. However, this does not preclude the possibility that he began excessive drinking because of a self-condemning attitude. It may well be that he previously considered himself unworthy of society and therefore deserving of punishment or even elimination from human intercourse. He can achieve temporary elimination by drinking himself into oblivion, even though this is only subjective elimination, because he still exists physically. And the subjective elimination of his unworthiness is possible even short of oblivion, since fairly small amounts of alcohol reduce his self-critical faculties and allow him to think somewhat better of himself. If he had been helped to be more generous toward himself, perhaps it would never have been necessary for him to resort to excessive drinking. Had he been helped with self-appreciation with the first evidences of overindulgence, maybe it would have been relatively easy for him to get himself in hand. All too frequently, however, his very early symptoms bring down an avalanche upon himself—an avalanche consisting of his own and other people's attitudes. These tend to establish his alcoholic course.

One more question arises. If the alcoholic drinks because of his attitude toward himself, how has he come to have such an attitude? Here lies the tragedy of the situation. The answer can be found only in the alcoholic's formational years of childhood when he was first made the victim of attitudes, and when he was still much too small to be other than totally dependent upon others. If alcoholism is ever to be substantially reduced, there must be not only widespread education about the nature of the illness itself but also a major social effort to gratify the basic emotional needs of children.

COUNSELING THE ALCOHOLIC

By REV. R. P. SIEVING*

● *The minister can do much to relieve anxieties and encourage growth.*

THE same techniques of sound counseling which apply in aiding stricken and afflicted souls in general also apply in the case of counseling alcoholics. These principles have in general grown out of the science of dynamic psychology. We are here dealing with the needs of troubled souls.

We counsel alcoholics because they need a listener, they need to confess their problem, they need understanding, and they need to grow towards maturity. Another way of saying this: In counseling we make rapport by being good listeners; we gain data given us by the counselee; we make an interpretation; and arrive at a tentative solution.

What is counseling? It is not giving advice, nor is it telling the alcoholic what to do and what not to do,

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nor does it mean that we tell him to stop drinking, nor is it a condemnation of his drinking habits. Counseling the alcoholic implies a responsive relationship arising from an expressed need to work through difficulties by means of emotional understanding and growing responsibility.

Of course, we need some method in counseling. But method, regardless of how sound from a psychological point of view the principles may be, is not the whole story of successful counseling. Counseling also involves an attitude on the part of the counselor.

Attitude Important

In order to be of service to the counselee, we the counselors, need to have a genuine warmth as we listen; we must display a sincerity; we must have depth of spirituality. These cannot be manufactured by methods. The counselor's attitude is perhaps more important than his method. Method gives us wisdom, yet method can be used unwisely. There is always danger that we become a bit legalistic. We will be more successful if we use good methods wisely in the spirit of love for mankind in general.

Discard Prejudices

In counseling alcoholics, our attitude with reference to alcohol, alcoholism, and the alcoholic in general is very vital. We must first rid ourselves of all negative attitudes about alcohol. We should examine our prejudices and discard them as unsound. As pastors we are often prone to condemn the alcoholic before we hear him out. That is loveless judging rather than sound counseling. We must learn that alcoholism is not necessarily a lack of willpower. Nor can we help the alcoholic by praying with him at the drop of the hat. Perhaps more prayer preparing ourselves to be fit counselors would be in order than the ostentatious praying often done with alcoholics. We are perhaps inclined to be impatient with alcoholics or with their jumbled story as they tell it. We must discard this negative thinking if we are to have some success in counseling.

This brings us to the first step in the discussion of interpersonal relationship with the alcoholic: Listening.

Art of Listening

It is the counselor's bounden duty to be a good listener. There's nothing new about this re-discovery of the art of listening. Good pastors throughout the centuries have practiced it. Listening is a skill. It does not merely mean remaining silent while the alcoholic speaks. After the alcoholic has come to your study or wherever you counsel, a few opening remarks, putting him or her at ease and making the person feel genuinely wanted, are in order. In so doing you may even define the situation, encouraging free expression, and assuring the person you wish to be of whatever help and service he or she may ask for or suggest.

Sometimes alcoholics will "size up" the counselor for awhile with all manner of irrelevant questions before they open up. The alcoholics have an extremely sensitive nature. If for any reason they suspect that we are not sympathetic with their problem, it is difficult for us to establish rapport, that fine close interpersonal counseling relationship so essential to get at the root of the problem.

As counselors who are trying our best to understand the problem, we should permit the counselee again and again to lead the conversation throughout the interview. The coun-

selor, like the center on a football team, takes the ball only to pass it on to another who carries it forward. Occasionally we facilitate the flow of discussion by a well chosen question, quite general in nature, without giving the impression that we are trying to direct him to speak towards a counselor-chosen goal. We must never force the issue. As we listen, we do more than physical hearing. We devote our complete attention to the person speaking; we live through his experiences with him so that we get the feel of what it means to be in his predicament.

Genuine Concern

We must stay close to the alcoholic's ego. We should listen with all our heart, mind, soul, and strength. We must show a genuine concern for our counselee so that we get a full appreciation of his problem. An occasional "uh huh" indicates that we are feeling with him. Just where we respond and with what inflection is something that each of us must practice for himself. This sort of response can't be taught; it must be felt as we enter into empathy or real fellow-feeling with another human being.

We should restate what the alcoholic has said, but must be careful to restate only what the counselee has expressed, and not what we think he has alluded to. If and when we ask questions, we should remember to ask *tiny* questions. We should avoid the impression that we are gathering together a case history or preparing next Sunday's sermon or writing a book or article for a conference. Staying close to the ego of the counselee is essential because the alcoholic is more suspicious and more sensitive to implied criticism or implied censure than almost any other subject of pastoral counseling. Therefore, we must use the word "we." For example, we might ask: "Now what do *we* find in the situation? What would *we* do with this problem you have brought?" Just such a simple technique as this helps the counselee feel important. We are on his team. We are on his side. Even when he leaves our study and goes on a spree, we are still on his side because we wish to help him.

The alcoholic is usually "eaten out" with guilt and he is also beset by much hostility and hatred—hatred for himself, hatred for his father-image, hatred for his family, hatred for his church etc. Much of it is unconscious, but it is present. As we listen, he may quite suddenly turn on us in condemning criticism. We shouldn't let that upset us. He doesn't mean what he says about us; he is perhaps taking out his anger on us about someone else. It will pass over. We must be shock-proof and become hardened to such criticism. Often we are called upon to be pin-cushions, but if the hostility of people who come to us gets under our skin, we are simply not good at counseling. We mustn't reassure the counselee from the angle that his sins could not be as bad as he pictures them.

Misdirected Interview

Here is an example of a misdirected interview. The alcoholic came to the pastor and began to pour out all manner of self-condemnation and remorse. Feeling that the counselee's self-blame was exaggerated and distorted, the pastor tried to reassure him, pointing out that after all there were seemingly good reasons for his actions. Each time the alcoholic tried again to express his deep feelings of guilt and despair, the pastor pointed out that things weren't as bad as he seemed to think. This interview broke up prematurely, because the pastor just did not let the counselee

finish talking. Reassurance of this kind does not reassure. The alcoholic fully realizes and understands the damage he has wrought in his life, in that of his family etc. By such attempts to reassure, the counselor simply gives evidence that he does not understand the problem.

At some point in this first interview we will have the chance to present some basic facts about alcoholism, such as the reason why people drink, that recovery and rehabilitation will take time etc. We should never tell the counselee directly that we think he is an alcoholic. He will push us for a statement in this direction, but we should avoid giving him a direct answer. We should, however, point out the signs of what constitutes alcoholism, but we let him reach the decision by himself. For as soon as we made the decision for him, up would go his defenses, and all sense of rapport which we might have established would break down. We should always speak in a nonjudgmental way.

Need For Confession

We counsel alcoholics, too, because they have a need for *confession*—to express their needs. The scientific counterpart of confession is *catharsis*. As a cathartic, the confession purges out the constipated emotions and cleans out the burden of damned-up tensions and apprehensions that plague the health of the soul by their insidious attacks from within. The need for confession is the need on the part of the counselee to give expression to the guilt within him. He must have opportunity to give vent to the destructive emotions of anxiety and resentment which are usually associated with guilt. The alcoholic is often a very resentful person, resentful of his family, of his past and present situation, of his boss, his fellow worker, of everyone in general. He often feels inferior, and so he resents anything and anyone who threatens his security. He must examine his resentments. Are they justified? Are they harmful to happiness? The counselee does not merely relate these feelings, but by relating them he actually releases them in the presence of the counselor. Thus, in instances, the counselee sees the irrational side of such feelings, and eventually finds his own solution for them, depending on his religious and other orientation.

Pride Is Obstacle

It is not easy for the alcoholic to be truthful. He has lived a lie much of his life, trying to cover up his drinking, hiding his liquor, thinking that no one else besides himself knows what's going on. It is not always easy for the alcoholic to make a clean breast of things. Natural pride is quite a block in the path of free confession. The alcoholic is extremely reluctant to admit his actual needs and his deficiencies, especially if the counselor also happens to be his pastor. He fears that his pastor will think all the less of him because of his sins. Therefore we must do all in our power to accept the counselee as worth more than the mistakes he has made. We shouldn't show any alarm or become easily upset by the sordid story our patient has to reveal. We musn't let ourselves preach or condemn, and should try to remember that we are endeavoring to help the victim of alcohol see his errors by letting him place all his cards on the table. Therefore we must do nothing to prevent the free flow of confession.

As the releasing of feelings and past wrongs are accepted by us without disapproval, the alcoholic is able to go more deeply into the painful anxieties and memories he has heretofore felt necessary to hide under

defensive repression. He can be his true and honest self in our presence because we respect him as a person, a blood-bought soul worthy of our best efforts.

Confession must be followed by assurance that there is forgiveness. Somewhere along the line in this confession we wish to get across to the alcoholic that in spite of all his past behavior, God is willing to forgive him. Of course, forgiveness implies a determined attempt to amend our sinful ways. And so, in a subtle manner, we get across to him that since God is willing to always forgive, he also desires to help us overcome our ways of ill-doing. Such means of making amends includes taking decided steps toward accepting help from a clinic, from scientifically trained help towards rehabilitation.

Recovery Slow

Let's not create the impression that we will be disappointed if the alcoholic does not stop drinking at once. We may as well make up our minds that he will have some more bouts with liquor. It took a long time to make the alcoholic what he is at this stage, and it will take a long time to undo all those immaturities and character defects. Recovery from alcoholism and rehabilitation is not an overnight process, just as the process of growing into maturity is not something that comes overnight. Similarly, counseling of the alcoholic will take time. We want the alcoholic to know that God is ready to receive the prodigal, although we will certainly not call him that. But we must assure him that somebody *does* care. Alcoholics feel that nobody loves them. We must assure the counselee that God *does* care and that He has provided ways and means to overcome his difficulty, or to learn to live with the problem without the use of alcohol. God works through human agencies, such as rehabilitation centers, alcoholism educational programs etc.

A natural outgrowth of the confession is understanding. The alcoholic needs to understand himself, and the counselor needs to understand his counselee. A person with problems usually has difficulty understanding himself. To understand himself and his problem the patient must get out from inside himself and lay the problems on the table where he can take a good look at them. That's the purpose and the aim of the confession. The alcoholic is often surprised at the things he says. He sees things in a different light by objectifying the problems through self-expression.

Understanding Important

As counselors, we accept these developing insights, even though we may rightly feel that they are not adequate. Perhaps the alcoholic does not yet see his problems in the right light. We musn't let that surprise us. He has floundered around all his life, so there is no immediate hurry to have him see everything in the right light at once. Give him time and opportunity to study himself more. We, as counselors, must beware not to work out the plan or tentative solution for the alcoholic. For instance, when the inebriate says "I'm beginning to see why I started drinking at that point. I think I was trying to punish my family, we musn't reply with "I've thought that for weeks—ever since our counseling sessions began." A better answer would be "Well, it might possibly be so. Tell me other reasons why you think this might be true. Suppose you test yourself at home, and see if you find this is the case." The alcoholic may come back a week later and tell you that he has found out that this isn't the reason he drinks. And although

we may not have found the real reason for his drinking, we have helped our counselee to have insight into himself, and thusly have guided him towards first steps to maturity.

The understanding that the alcoholic receives in the course of the counseling process could perhaps have been given him by the counselor during the first interview. We could have easily speeded up our program of counseling, but would it have been *effective* counseling? After that first interview, we hope that something has changed in the counselee. That change is his degree of growth. Through release of destructive emotions and his relationship with the counselor, the alcoholic grows to the point where he arrives at an understanding of himself, and the desire to do something about his problem grows within him. He must realize that he needs help. Coercion, and persuasion of the mandatory type will get us nowhere. Only when the alcoholic reaches the stage where he declares: "I'm ready for help; where can I get it?" is he growing as a result of our counseling sessions. He begins to see his problem and the eventual solution to it in a new light.

This brings us to the point where we ask: "What has really been the aim of pastoral counseling with the alcoholic?" *Referral* is the answer. Have we spent all this time, perhaps three or four counseling sessions with the alcoholic only to refer him to someone else? Why certainly we have.

The minister who works as an isolated counselor usually has a low rate of success with alcoholics. I know this is not flattering to our ego. But as wise counselors dealing with alcoholics, we learn right from the start to work in conjunction with Alcoholics Anonymous, the medical profession, rehabilitation clinics etc. If the alcoholic is not willing to receive such scientific help, then the pastor's function is to counsel him preparatory to accepting help. To create such willingness may not result after one or two counseling sessions. Sometimes we only plant the seed, give him literature to read at his convenience etc.

Counseling for referral may not seem "glamorous" enough to some counselors who might be striving for ego-gratification. But rest assured that counseling for referral is no small part of the pastor's work. The task has been well done, indeed, if the minister has, by his understanding attitude, his counsel, and his friendship made it possible for an alcoholic to go to some specialist in the field of his own free will. No minister need feel ashamed that he himself was unable to tackle the problem of the alcoholic if he has helped that person seek professional assistance elsewhere. It is important to point out in conclusion that during this time the minister never relinquishes his pastoral responsibility simply because the patient has been referred to someone else.

NCARP HAS TV PROGRAM—"INTO THE LIGHT"

The NCARP is currently producing a 13-week "live" television program on WUNC-TV, Channel 4, Raleigh. The show, entitled "Into The Light," runs every Tuesday night at 8:30, beginning February 9, through May 3rd. ARP Education Director George Adams is moderator. The program series will cover many phases of alcohol problems, including causation, treatment, prevention, and the family involvement. Watch for "Into The Light" on Tuesday nights!

North American Association of Alcoholism Programs Receives Research Grant

National Institute of Mental Health approves $1,100,000 Federal Grant to NAAAP for special Commission to launch long-term study on all aspects of alcoholism problem.

THE date of November 24, 1959 will perhaps be recorded as one of the greatest historical dates in the first ten years of growth of the North American Association of Alcoholism Programs. Dr. Arthur S. Fleming, Secretary, U. S. Department of Health, Education and Welfare, has officially announced that the Cooperative Commission On The Study Of Alcoholism, previously known as Project X, was approved by the National Institute of Mental Health which is under the directorship of Dr. R. H. Felix. H. David Archibald, President of NAAAP, announced that a federal grant of *$1,100,000* will be forthcoming to support the work of the new Commission.

The need for such a project was first discussed in January of 1959 when the members of the Executive Committee of NAAAP met with officials of the NIMH in Washington, D. C. It was mutually agreed that there is immediate need for a study to include a total review of the field of alcoholism—what has been done, what the present status is, and where we need to go in the future. A special NAAAP committee consisting of H. David Archibald, Ontario, Canada, Dr. Dudley P. Miller, Connecticut, Dr. I. Jay Brightman, New York and Harold W. Demone, Jr., Massachusetts was appointed and authorized to develop plans for such a Cooperative Commission. This committee met several times during the 10-month period from January 24, 1959-November 24, 1959.

Some of the aspects of the Commission, its purpose, and its goals have been summarized by Mr. Archibald as follows:

In broad terms, the new Commission will study what is being done

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already and what should be done in the future to deal with alcoholism as a major health problem. The study and investigation will extend over a five-year period and will reach into every state and province where relevant work is under way in the treatment and rehabilitation of alcoholics, in research into the causes and consequences of the disorder, and in public and professional education about it.

Under a scientific director, as yet unnamed, the Commission will function from a major American university center and will employ "task forces" to deal with particular aspects of alcoholism. These "task forces" will be set up at appropriate points in the U. S. and Canada. Funds additional to the million may be sought by institutions or bodies whose work can be integrated with that of the Commission or whose help would be useful in reaching the overall goal.

This overall goal is stated in the broadest possible terms so that nothing which can be thought of to contribute to the understanding and relief of alcoholism will be neglected. At the same time, the Commission's task is by no means left nebulous and unclear. Scientific knowledge of alcoholism as a disease and as a social problem is to be examined and re-evaluated. The many organizations which deal with alcoholism or bear upon it in significant ways will be brought under fresh study. Nothing is to be overlooked—lobbies of all kinds surrounding the use of alcohol, the Temperance movement, sales programs, law enforcement methods, health, welfare, and educational agencies will be systematically examined.

The goal is to learn how alcoholism has reached its present state and proportions in the United States and Canada and to search out better ways of dealing with this problem.

When appointed, the commission's scientific director will be responsible to a 25-man body of eminent scientists and laymen, members of the Co-operative Commission. These members will be appointed by an existing interim commission comprising the following: H. David Archibald, Chairman; Dr. Nathan Cohen, Dean, School of Applied Social Science, Western Reserve University, Cleveland, Ohio; Dr. Harold E. Himwich, Galesburg State Research Hospital, Galesburg, Illinois; Professor Herbert H. Hyman, Department of Sociology, Columbia University, New York; Dr. E. M. Jellinek, General Consultant—Alcoholism Foundations of Ontario and Alberta; Mark Keller, Managing Editor, Quarterly Journal of Studies on Alcohol, Yale University; Dr. Andie L. Knutson, School of Public Health, University of California; Dr. Abraham Lilienfeld, School of Hygiene, Johns Hopkins University, Maryland; Dr. Theodore Newcomb, Department of Psychology, University of Michigan; Dr. Benjamin D. Paul, Harvard School of Public Health, Boston, Massachusetts; Dr. Lloyd E. Ohlin, Columbia University, New York; Dr. John R. Philp, Division of Alcoholic Rehabilitation, California State Department of Public Health; Dr. J. H. Quastel, Professor of Biochemistry, McGill University, Montreal, Quebec; John R. Seeley, Director of Research, Alcoholism Research Foundation, Toronto, Ontario; Dr. Benson Snyder, Massachusetts Institute of Technology; and Dr. Robert Straus, Department of Behavioral Science, University of Kentucky.

It should be pointed out that the 25-man Co-operative Commission, though initiated and planned by the representatives of the NAAAP, will be a body separate and distinct from the Association.

The school alone cannot handle the problem of alcohol education. By providing a warm and happy home filled with love and security, parents can do much toward helping the child cultivate healthy attitudes and values.

THE ROLE OF PARENTS IN ALCOHOL PROBLEMS

By JOHN J. PASCIUTTI, A.M.
SUPERVISOR OF ALCOHOL EDUCATION
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LOOK around a group of children playing together. There's Nancy, whose family has wine on the table at meals. In Peter's home, beer is part of Father's weekly poker game. Alice's mother is the leader of the local Women's Christian Temperance Union. Joe's parents come home a little tipsy from twice-yearly parties. Jimmy's family are abstainers from choice. Patty's college-age brother has a cocktail with their parents before dinner. Jeff has heard his alcoholic uncle spoken of in whispers. Dorothy's cousin works in the State Liquor Store.

What kinds of attitudes and values about alcohol have these children gained from their homes, their churches, the social groups to which their families belong?

What kind of guidance will help each of them grow up so that he or she will not need to turn to alcohol for relief or escape?

How can families help in alcohol education? May the work be left to the school to do it alone?

Education is always a shared proposition. School and home, the teacher and the family, work together. Alcohol education is not an exception.

Alcohol education, we feel, consists in helping children grow up without the kind of strains and conflicts that make some people take to drinking for relief. Put it another way: alcohol education is education in healthy

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living aimed towards good marriages, warm and loving homes, satisfying work, and comfortable relations with other people.

In this kind of education, the school and its teachers can help but they cannot do the whole job. What the family does is basic. A child's attitudes and values are established well before the child enters school. How? They come from his family. His ways of relating to the world around him and to the people in that world are also developed very early. How? Again, through living in the family.

How does this relate to alcohol education? Dr. R. G. Bell of Toronto gives some clues:

"Those childhood situations that mold the child in such a way that as an adult he experiences both tension and loneliness provide part of the 'seed-bed' (for later alcoholism). For example, let's consider the overdisciplined child. He's hurt by his own parents. If he couldn't turn to them in times of need you can be sure he is not going to turn to other people for help when he needs it as an adult . . . If the person is psychologically crippled or hurt as a child, so that he cannot turn to other people in times of stress, he has to turn to something; and he may turn to chemicals . . . which will reduce his awareness of a world to which he reacts with too much tension and in which he experiences too much loneliness."

Another way of saying this is that the child's very early experiences

have a lot to do with the kind of adult he will become. We need to learn to trust and like people early in life. We want to relate easily to others, to make good friends and to be a good friend ourselves. The person who feels he can't trust, or believe in, his parents, is going to have difficulty trusting or believing in anyone else. In consequence he will certainly be unable to believe in himself. There are many escapes from this personal misery (none of them a good substitute for maturity) and alcohol is just one of them.

For the very young child, the family is the whole world. It is the first society he knows anything about. It is the first school in which he learns about people. And it is the way people relate to each other that determines what a society is like. Our American society, as we all know, depends on people trusting each other and working together. If the family has within it a lot of trust and liking and ability to work together, it is a good first society for a child; a good school in social living.

If his first experiences have been unhappy ones, the child may well have difficulty in relating to other people. He may grow up to be an adult who needs alcohol as a "social lubricant" to ease the tension in social relations or as "pain killer" to dull his psychological misery.

As Dr. Bell says, "If the child reaches adulthood able to experience a sense of security and worthwhileness in his relationships with people, and relates to them easily, there's no room for another unhealthy way of life to develop."

We have spoken of the difficulties the overdisciplined child may face. Parents who are too demanding deprive the child of needed success along the way. The overprotected child faces difficulties, too.

Overprotection should not be confused with love. We love a child for himself, as a person separate from us; as someone we respect. Overprotection indicates an unwillingness on our part to let go. It implies a lack of confidence, an unwillingness to let the child be himself and do for himself. Making things too easy deprives a youngster of the self-confidence that comes only from successful experiences resolving his own problems.

Overprotection

So overprotection is like overdiscipline. When we overprotect or overdiscipline we fail to see the child as an individual with his own rights and needs and feelings; we do not give him the respect on which all love is based.

The overprotected child may be as lonely as the overdisciplined child, and for the same reasons. He has not learned at home to relate to other people on a person-to-person basis. But there are differences as well as similarities. The overdisciplined child tends to turn away from people, for he has been hurt when he turned to them. The overprotected child tends to lean on others, for he has never learned to be a separate individual. Both need and want love; neither knows how to go about getting it. Both feel inadequate, the one because he has learned to distrust people and therefore can't work with them or find the satisfaction of being close to them; the other because he has never learned to stand on his own legs and be independent.

Therefore the child's first world, his family society, can be one with too much discipline or one with too little independence. In either case, the child learns as he lives. And what he learns, be it the sense that others are not to be trusted or the sense that he isn't allowed to be himself, may have a lot to do with

his personal relations later on.

Parents build with their hands and their imagination, with their care and devotion, with their interests and their activities, this first social world in which their children live. How do they build?

If the parents truly love each other, the cornerstone has been laid. If they are happy, productive people, at ease in their jobs and their community life, another foundation stone has been added. If they are relaxed and happy with their children, the foundation is complete. It ought to be a solid one, for on it will rest the brickwork of the future: a soundly constructed home within which the child feels he has a valued place of his own; a good place from which to venture forth and to which to return.

A child growing up in such a home is unlikely to have any need for alcoholic escape.

It is no trick with words to say that by living in the home, the child learns to get along in the world outside the home. For it is in his early years at home that he learns values: what is right and wrong, what is good and bad, what he will like and dislike. And while he learns these values largely from his parents—who learned values from their parents—they are more than family values. Here at home, the child is learning what the wider world accepts and believes. He is becoming a member of a culture, just as his parents are members of the culture, not a little island apart from it.

He learns simple things and complicated things. He learns how to hold a fork, which is relatively simple, and how to talk, which is quite complicated, and he learns when to do each of these. He also learns something far more intricate—a system for evaluating the way people behave. He learns this in the only way he can—by living in a family which judges, measures, evaluates constantly. So without knowing it, he comes to judge and make values, too. Shortly after he has learned to talk he knows that certain things are approved or disapproved, that certain people are considered good or bad.

And he learns habits. Some of them, like cleanliness, are common habits. Almost everyone the child will ever meet as he grows up will have the habit of being at least passably clean. But some of the habits he learns from his family may be special to that family or to a group of families. Such habits include habits about the use of alcohol, for in one family it may be habitual to drink wine at meals—Nancy's family, for instance, to return to the group of children we looked at on page one—while in another family total abstinence may be the habit—Alice's very likely. Research indicates that parental example is an important factor in determining whether young people drink or abstain later in life.

Values Relative

The habits and the values are likely to go hand in hand. The habitually clean child puts a "good" value on cleanliness and a "bad" one on being dirty, because his family does. Nancy is likely to have a "good" feeling about the wine her parents drink, because they have a good feeling about it and because mealtime at her house is a pleasant occasion. Jeff, on the other hand, is almost certain to evaluate alcohol as "bad" because of what he has heard whispered about his alcoholic uncle, and he will associate that value with his own family's habits about the use of alcohol.

So the family transmits the culture to the children: a culture which

includes ways of doing things, habits, and a scheme of values. Many of these things will be common things which everyone shares, and the fact that the child learns them makes it possible for him to understand others and work with them. Some of these things, however, will be different from family to family and thus from child to child. They are part of what makes people so fascinatingly different from each other, and these differences are a valued part of our pluralistic culture. They also call for acceptance, tolerance, and a broad kind of understanding.

Family Attitudes

In alcohol education we help children understand each other's attitudes and values. This is obviously an area in which teachers and parents can profitably work toegther, respect each other, and become friends. Families can encourage this widening of relationships, or they can discourage it. We may return again to the group of children we have seen playing together. How do their parents regard the fact that they do play together?

For example, what does Jeff's mother think about his playing with Joe? Jeff's mother probably has strong feelings about alcohol because of the tragedy of Jeff's uncle, who can't control drinking. It is likely that she knows Joe's parents drink a little too much a couple of times a year. Does this mean that she will consider Joe an unsuitable playmate for her Jeff?

Family intolerance can undermine the work being done by teachers in helping children to understand why there are many attitudes possible towards alcohol, and to see that decent, wholesome, fine people may represent a wide variety of these attitudes. For a family to support a teacher in this kind of tolerance certainly doesn't mean that the family must give up its own attitudes, nor that it should give up its belief that its attitudes are good ones. But may one not have strong personal feelings and still be tolerant of the feelings of others?

Often the school is the child's first important experience of the world-away-from-home, the "outside world." The teacher then becomes one of the first representatives of this bigger world to play a major part in the child's life. She serves as a guide on the path from a life centered in the family to one which will be increasingly centered outside of it—until the grown child builds his own family.

Because of her major part in this transition between home and away-from-home, the teacher is someone of importance to the child's family as well as to the child himself. Between teacher and family there can develop the most creative kind of relationship, in which each helps the other in the adventure of education.

This asks that families understand what teachers are doing, just as teachers seek to understand the family backgrounds from which come the children in their classes.

Sense Of Responsibility

One Vermont teacher—a member of a workshop in alcohol education—talks about her way of working with young children in these words:

"I attempt to give each child in my group a sense of responsibility to their group—more easily done in a rural school situation, because it's more like a family or a community. In my particular group, with ages from five to twelve, the older children feel responsible for the younger ones, and the younger ones gain a feeling of security when they discover that the older boys and girls want to help them. Children are giv-

en tasks to develop responsibility—raising and lowering the flag, erasing boards, getting art materials, for instance. When a child does a task well, a word of praise helps. When a child has not shown responsibility, a quiet discussion with the child helps."

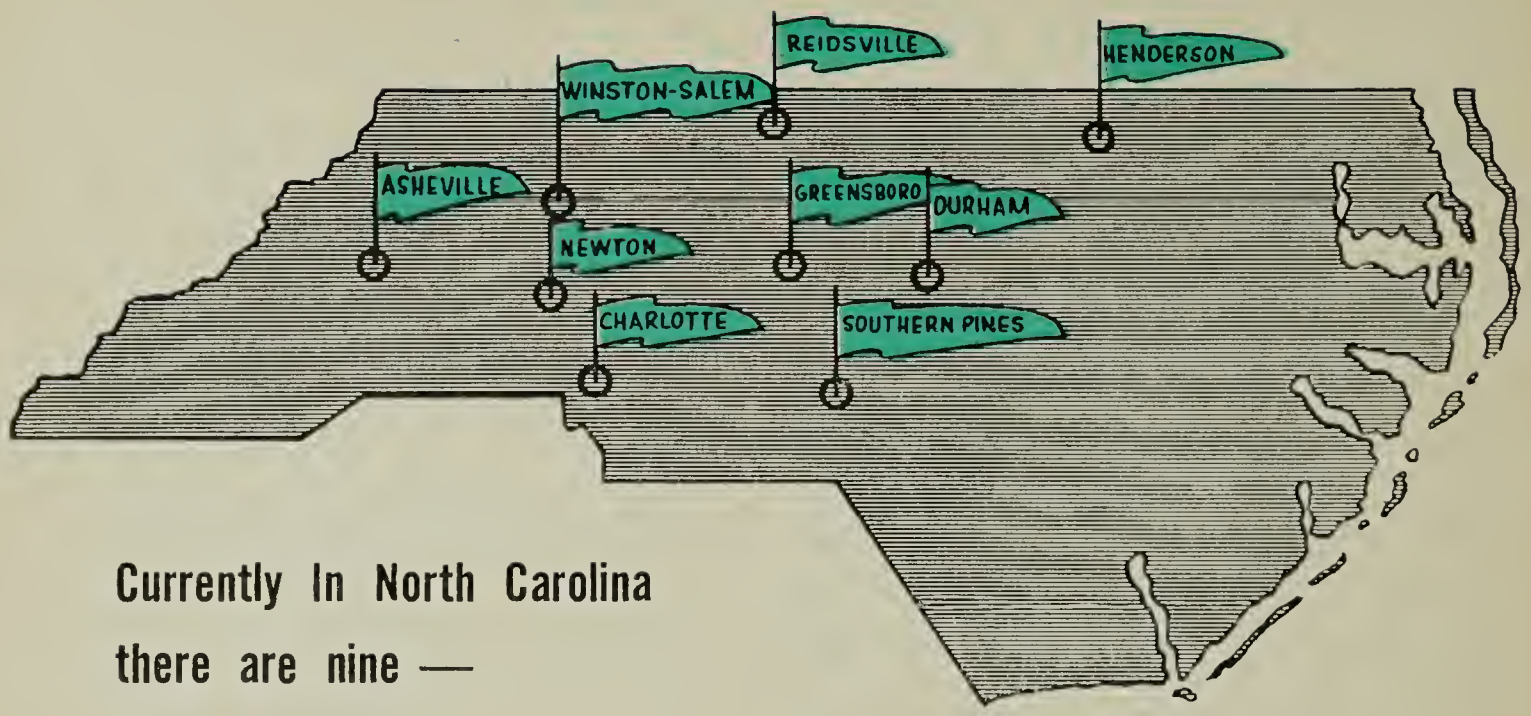
And, she adds, the teacher must help the child to "a feeling of confidence, a feeling on the part of the child that here is someone who will try to understand and help."

Dr. Bell points out that "the prevention of a way of life involving dependence on alcohol puts the whole emphasis on the normal, healthy growth of the child." It is towards just such normal, healthy growth that this Vermont teacher is working. How fortunate she is if she has the parents of "her" children working with her, providing the loving warmth which forms the basis for future happiness.

Love is hard to define. You know it when you have it.The child knows it, and knows also its absence. Let us say that it must include the fact that the parents in the deepest way want, accept, and respect their child —not as a plaything, not to prove something to themselves, not to show off, but simply for himself.

Given unconditional love as a beginning—and more than a beginning, for it must be a consistent, secure, and permanent thing in the child's experience—not much can go wrong.

Families come in all shapes, sizes, and colors, an infinite and refreshing variety. They are poor and rich and in-between: quiet and calm or full of excitement and activity; housed in everything from trailers to mansions. And most of them have within them the strong elements of love and care and sharing which are the best preventive medicines in the world against the disease of alcoholism.



Currently In North Carolina there are nine —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—

Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)

Educational Division, Board of Alcohol Control
West Wing, Parkway Office Building, Asheville
Margery J. Lord, M.D., Administrator

CHARLOTTE—

Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellermann, Director
William Hales, Associate Director

DURHAM—

Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Executive Secretary

GREENSBORO—

Educational Division, Alcoholic Board of Control
Greensboro

Mr. Worth Williams, Executive Secretary

Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Mr. Worth Williams, Executive Director

HENDERSON—

Vance County Program on Alcoholism
Reverend Edward Laffman
Information Center
221 S. William St.
P. O. Box 233, Henderson

NEWTON—

Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton)

REIDSVILLE

Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SOUTHERN PINES—

Moore County Alcoholic Education Committee
Rev. Martin Caldwell, Director
P. O. Box 1098, 350 S. Ridge St.
Southern Pines

WINSTON-SALEM—

Forsyth County Program on Alcoholism
Woodland and Seventh Streets, Winston-Salem

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

MARCH - APRIL 1960

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

Into The Light

Understanding The Alcoholic

Reading The Signs Of Mental Health

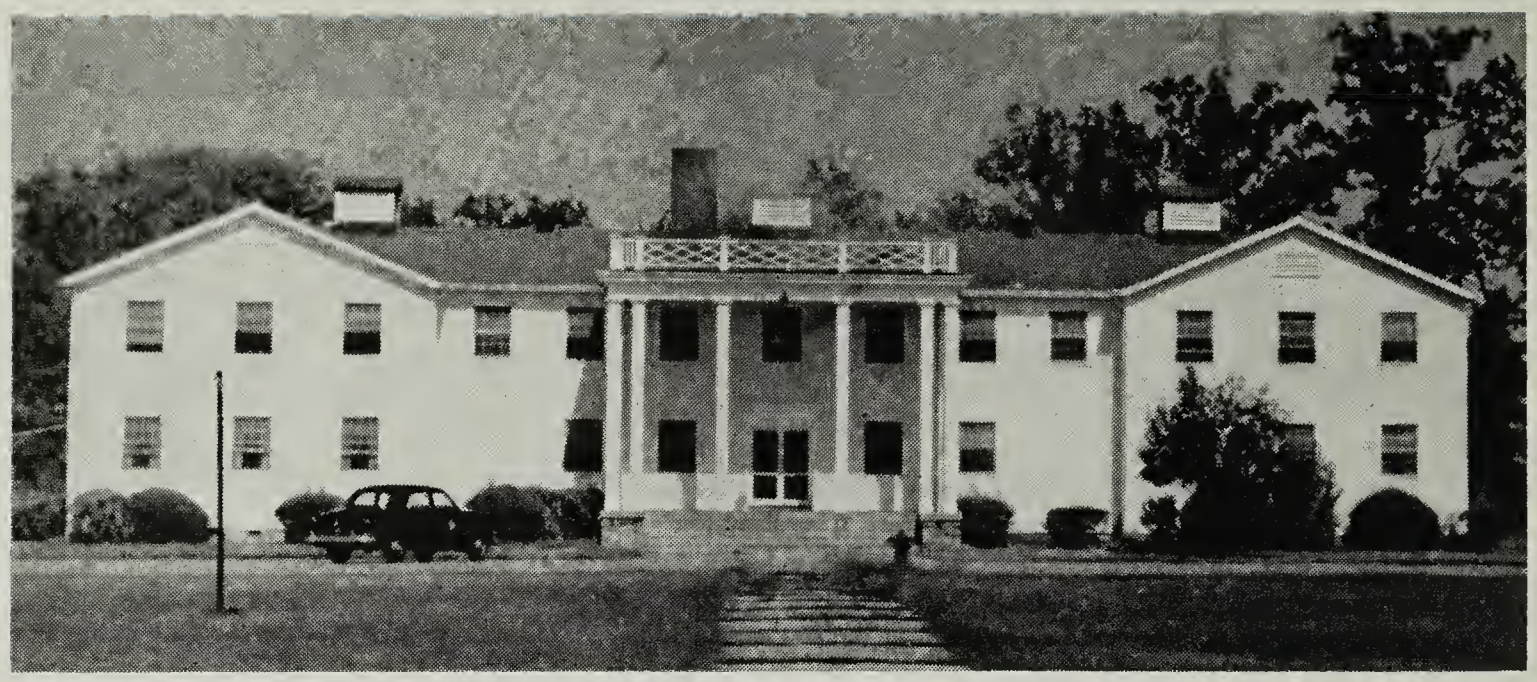
The Chronic Police Case Inebriate

Babes In The Woods

What's Brewin'?

Letters To The Program

N. C. ALCOHOLIC REHABILITATION CENTER



BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Medical Director, one other physician, a clinical psychologist, a psychiatric social worker, a vocational rehabilitation counselor, a recreation director-occupational therapist, and a full attendant staff.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written or telephone application to the Medical Director, Alcoholic Rehabilitation Center, 406 Central Avenue, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.
3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illness. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

NORBERT L. KELLY, Ph.D.
Associate Director

GEORGE H. ADAMS
Educational Director

DONALD MACDONALD, M.D.
Medical Director

ROBERTA LYTLE, R.N., M.S.Sc.
Psychiatric Social Work Consultant

INVENTORY

VOLUME IX NUMBER 6

MARCH-APRIL, 1960

RALEIGH, N. C.

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JACKIE RANSDELL
Assistant Editor

ELEANOR BROOKS
Circulation Manager

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Write: INVENTORY, P. O. Box 9494, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

A feature designed to help you keep posted on developments in the field of alcoholism.

ONTARIO, CANADA: The Ontario Temperance Federation reports Mr. E. D. McRae, Executive Director of the British Columbia Alcoholism Foundation, has estimated that alcoholism and the problems caused by excessive use of alcohol costs British Columbia about $85,000,000 annually. This estimate is based upon case histories of clinic patients.

MINNEAPOLIS, MINN.: The Minnesota "Mental Health Progress" reports that out-patient psychiatric care is now available to forty per cent of Minnesota residents within their own community. Over one-half of the eighty-seven counties have either applied for, or have indicated intent to apply for, grants-in-aid to establish local mental health centers. Only three years ago, ninety-three per cent of professional psychiatric services available in Minnesota were concentrated in the metropolitan areas.

RALEIGH: The state-wide Nurses' Institute on Alcoholism which was scheduled for March 10 in Morganton, N. C. and which was postponed because of an unexpected heavy snowfall, has been rescheduled for May 4 in Greensboro at the Home Economics Building at the Women's College. We certainly hope that the Institute will not have to be cancelled this time. Surely it won't snow in **May!**

CHAPEL HILL: On April 6, the NCARP joined the Office of Continuation Education and the Department of Psychiatry of the University of North Carolina School of Medicine in conducting a one-day Institute on Alcoholism for Physicians. It was the first of its kind to be conducted for General Practitioners, Internists, and other physicians in North Carolina. Featured as speakers for the occasion were men of extensive knowledge and experience in treating the complex illness of alcoholism.

QUEBEC, CANADA: Quebec is now the sixth Canadian province to establish an alcoholism program. Others are British Columbia, Alberta, Saskatchewan, Manitoba, and Ontario.

CHARLOTTE: Reverend Joseph Kellermann, Director of the Charlotte Council on Alcoholism, recently attended the annual meeting of the National Council on Alcoholism, Inc., which was held in New York City. At one of the sessions, he led a one-hour discussion on the purposes of the information center. William Hales, the Charlotte Council's Associate Director, plans to attend the National Council on Alcoholism's Fifth Annual Training Course, "Alcoholism and Community Action," to be offered at Columbia University-Teachers College in New York June 13-24.

GREENSBORO: At a meeting of representatives of the State's alcoholism programs recently in Greensboro, it was voted that the group organize under the name of Alcoholism Programs of North Carolina. The next meeting of the A.P.N.C. will be held in Greensboro on May 5 in conjunction with the Greensboro Council's Educational Week. The idea for this organization of State alcoholism programs was born at a similar meeting held in Chapel Hill last September.

COLUMBUS, OHIO: The "Alcoholism Outlook", published by the Columbus Area Council on Alcoholism, reports that a five day study course on alcoholism will be held at the University of Wisconsin from June 13-17. It will be sponsored by the Mid-West state programs.

ASHEVILLE: Mrs. Mary Smith, a health educator who is on leave of absence from her position as a home economics teacher in the county school system, is working part-time with the Buncombe County Board of Alcoholic Control. Since her employment in January, she has been orienting herself to the operation of the State and local programs. Her main objective at present is to aid in developing an educational program in both the county and city schools, and much of her time has been spent recently conferring with school officials to discuss and evaluate ideas and suggestions.

ONTARIO, CANADA: The Research Director of the Alcoholism Research Foundation of Ontario, John R. Seeley, has estimated that there are at least 2,010 alcoholics per 100,000 adults in Canada. This makes a total of more than 212,000 Canadian alcoholics.

High Regard

I have read "Inventory" with great interest and much benefit during the past several years and wish to continue on your mailing list. As it was suggested to me by a friend who was interested in alcoholism, I have in a similar way passed on to others my high regard for your fine magazine.

James B. Shuler, M.D.
Shenandoah, Virginia

Model Program

I would greatly appreciate it if you could send me any and all information which you can afford on your rehabilitation program for alcoholics.

In many cases tuberculosis goes hand in hand with alcoholism. Recently at one of our Boston tuberculosis sanatoria it was decided to open a "Halfway House" for the rehabilitation of alcoholic patients.

I recently discovered that North Carolina is a pioneer state in such a program and that it has met with much success. I sincerely hope that we can meet with the same success, perhaps using your program as a model.

Robert R. McCarthy
Public Relations
Boston Tuberculosis Association
Boston, Mass.

Louisiana to England

I am an alcoholic and am pleased to state that through the A. A. program of recovery I have been completely sober for the past two years. I have attained this sobriety through the 12 suggested steps of the program, through reading literature on all aspects of alcoholism, and through correspondence with other alcoholics. An A. A. correspondent in Louisiana has sent me a copy of your journal, INVENTORY, which gave me great satisfaction to read, and I am writing to ask if you could put my name on your mailing list for future issues.

Anonymous
Liverpool, England

Doctor Writes

Please add my name to your mailing list to receive the bi-monthly publication of "Inventory." I am concerned with alcoholism in the industrial setting and interested in all methods for rehabilitation.

Luther A. Cloud, M.D.
New York, N.Y.

Professional Help

I have limited contact with your informative and interesting publication, INVENTORY, and feel it would be a real professional help in my work as a practicing public health nurse. In our southern California communities the problem of alcoholism continues to grow, and we are assuming an ever increasing responsibility in the rehabilitation of patient and family. Would you kindly inform me if this publication would be available at this time?

Jane Salmon
Long Beach, California

VOL. IX, NO. 6 INVENTORY MARCH-APRIL, 1960

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

BABES IN THE WOODS

By **RALPH W. DANIEL, M.S.W.**

Delivered before the Second Annual Meeting of the Columbus Area Council on Alcoholism, Columbus, Ohio, October 29, 1959. Reprinted by permission of the author.

We're all beginners in the treatment of alcoholism, but some of us are older than others. An oldster asks a youngster some questions.

THE Columbus Area Council on Alcoholism is two years old. The Michigan State Board of Alcoholism is eight years old. Alcoholics Anonymous is about twenty-five years old. The Yale School of Alcohol Studies is about twenty-five years old. The first State alcoholism program is fifteen years old.

We are all "babes in the woods." Sometimes we whistle in the dark and make believe that we know what we are doing but, still, deep down inside we are "babes in the woods."

If we are to keep our own sanity, we must whistle in the dark a little,

but we must not lose sight of the reality that the woods of alcoholism are large, and thick and old and that we do not understand the dangers that lurk in the underbrush.

I come here tonight as a child that has spent six years in the woods. I entered the woods with some knowledge of human personality and some experience helping people with other problems. I have been associated with a State program that has encountered some of the dangers and has devised some primitive methods of survival and progress. We do not know the answers. We have not conquered the forest. We have a long way to go.

There are dangers in instilling the experience of one child into a younger child. If the older child may be going in the wrong direction, he has no right to say the younger child should follow his footsteps in the same direction.

My plan is to ask you some questions that a six-year old might ask a two-year old. I hope to stimulate your thinking in such a way that you will devise better answers than we have found. The questions will be followed by the experiences and any ideas that we now hold.

First Question

And here is the first question from a six-year old to a two-year old. *What do you want to be when you grow up?* What would you like to see in Columbus ten or twenty years from today? How do you think Columbus should treat alcoholics in 1970 or 1980 or 1990?

You may want for Columbus, hospitals and clinics and half-way houses and specialists, all dedicated to treating and rehabilitating alcoholics. You may want shining new resources adequately equipped to treat your estimated 20,000 alcoholics. You may want to have places where your social agencies, and your clergymen, and your police force, and your attorneys, and your courts, and your city planners can send alcoholics to get rehabilitated.

This may be your dream. This may be what you want to be when you grow up. This is not our goal. This is not our dream.

We believe that alcoholism is not basically different from other physical and emotional problems. We believe that the dangers that lurk in the forest of alcoholism are similar to the dangers in other forests. We believe that the lessons and skills that have been learned elsewhere can be applied to alcoholics. We believe that alcoholism is unique only because it has been ignored and we have allowed old wives' tales and superstition and folklore to keep us out of the woods.

These are the things that we set out as long-range goals. For Michigan we want:

1. Citizens who recognize that some people cannot drink in moderation and that those people cannot be blamed for the conditions that made them alcoholic. In other words, an informed public.
2. Police officers who have some knowledge of alcoholism and who consider helping alcoholics, as well as protecting the rights of others, as part of their job.
3. Courts and laws which recognize that help for the alcoholic is far more effective than is punishment.
4. Physicians who are ready, willing, and able to treat the acute phases of alcoholism and to use their skills to join with the community team that offers help for the chronic aspects of the illness.
5. General hospitals whose beds are available to acutely intoxicated patients as they are to diabetics, and nursing staffs who recognize

that there is more to alcoholism than intoxication.

6. Clergymen who are aware of the spiritual problems faced by alcoholics and their families and are ready to use their counseling skills to help rather than to condemn.
7. Social agencies who offer their help to families where alcoholism has intensified normal social problems and who use their skills to help the individual alcoholic.
8. Health departments that feel as much responsibility toward alcoholism as they do any other public health problem.
9. Employers who recognize the early symptoms of alcoholism in employees, and who protect the investment they have made in these people, by getting help for them before they jeopardize their jobs.
10. Schools that teach objectively.

This, then, is the dissertation of a six-year old.

You have a definite responsibility to set long-range goals. Whether you use our goals or devise goals of your own is your own choice.

Second Question

The second question from your six-year old neighbor is this:

How old are you? When I ask how old you are, I mean "How much progress have you made toward your goals?" Where do you stand between the problems out of which you were born and the goals you hope to reach?"

The idea that alcoholism is a treatable illness is like a gleam of hope in our dark forest. Many people are saying the words and blindly jumping on the bandwagon.

If we accept alcoholism as an illness, we must abandon certain ideas like "drinking too much is something to joke about," or, "to be able to hold one's liquor is a sign of manliness" or "Alcoholics lack willpower." If alcoholism is an illness, it is not primarily a moral problem. If alcoholism is an illness, then the law enforcement agencies and courts must abandon punishment and arrest as methods of handling alcoholics. If alcoholism is an illness, the employer must change his policy of firing alcoholics. If alcoholism is an illness, our laws must be rewritten and we must abandon some old concepts. If alcoholism is an illness, we must abandon the idea that we can solve the problems of skid rows by strict law enforcement and the physical rebuilding of Skid Row areas.

Abandon Old Concepts

Accepting alcoholism as a treatable illness means giving up old and deep-rooted concepts. We can judge progress as well by asking what old practices have we abandoned as we can by asking what new practices have we accepted.

It is hard to determine how old we are when we cling to the activities of infancy and reach for the activities of adults. Adolescence has been described as the period when we reach for an ice cream cone with one hand and a cigarette with the other hand and get strained in the process. Thus it is with alcoholism.

We need to take an inventory. We need to ask ourselves as individuals what we have been willing to give up in order to accept the new idea.

How old are you? It is not a simple question. It is an important question.

My third and last question is this:

How do you get along with your brothers and sisters? I want to speak of four siblings of alcoholism programs.

1. Temperance organizations
2. Liquor interests
3. Alcoholics Anonymous

4. Your new-born State program

Those of you who are parents and those of you who work with children will realize that children have a great deal of effect on each other. They quarrel and fight and compete, and tease and cooperate and connive together. Sometimes older children dominate their younger sibling. Sometimes young children idolize their older sibling and sometimes they rebel and become as different as possible. Sometimes they ignore each other.

Much of the future of the Columbus Area Committee on Alcoholism depends on how well you get along with your siblings.

Temperance groups are made up of sincere, conscientious people who have a long history of combating alcohol problems by combating alcohol. Their experience teaches them that the dangers of the use of beverage alcohol far outweigh any possible values that it might have. They would prevent alcoholism by voluntarily abstaining from alcohol. In some instances, they have advocated involuntary abstinence through prohibition laws.

Temperance groups have generally watched the birth of programs like yours with skepticism. They see dangers in calling alcoholism an illness, and they have difficulty accepting a new sibling that talks about one of the problems related to alcohol and still takes no stand on the "wet" and "dry" issue.

Some temperance groups accept alcoholism as an illness and they feel a responsibility to help alcoholics. I think that there are areas where your group and these temperance groups can work together. I hope that some of your members are active in temperance groups.

My experience is that there is a need for alcoholism programs and temperance groups to sit down and agree that there are areas of cooperation and areas where cooperation is impossible. We need to respect the differences of opinion and the integrity of each other. Much sibling conflict can be eliminated if we understand each other.

Much of the same could be said about liquor interests. These people represent a legal business. Like all business in a capitalistic society, their goal is to make money and push their product. Some of the liquor interests are well aware that some people should not drink at all. Farsighted people in the liquor business realize that any excessive or unwise use of their product may result in real personal disaster. Some of them see a responsibility in cooperating with alcoholism programs. You can work with these people but again it is important that you are as aware of your differences as you are of your

MEET THE AUTHOR

Ralph W. Daniel, M.S.W., is Executive Director of the Michigan State Board on Alcoholism.

agreements.

The third sibling is the twenty-five year old brother called Alcoholics Anonymous.

In many ways, A.A. is a strange brother who defies all the experts on child growth and development. It is not an organization—it is a fellowship. It has no rules and regulations or constitution or bylaws, but, rather, it has steps and traditions. It is a sort of secret society without formal structure.

A.A. was born in the woods. It came from the experiences of people bewitched by evil spirits and unable to get help from the medicine men of the tribe. Yet, in spite of all the unusual things about this older brother, he has developed an uncanny method of getting the spirits out of the lives of people who were bewitched. Most professionals are awed by the effectiveness of A.A. and they are, I am afraid, a little jealous of the successes and the place that A.A. holds in the hearts of the general public.

There are in A.A. many people who were poorly treated by society and the professions before they got into the A.A. These people tend to believe that alcoholism is a strange thing that defies the "pros." Some of them say that only the experience of alcoholism qualifies a person to help alcoholics.

There are other A.A.'s who say, "I found my help in A.A. but others may find help elsewhere." These people see a hope of a professional approach and of a cooperation between A.A. and the professionals. These people see the need to be friendly with their friends and they are willing to work for anything that helps alcoholics.

Our experience is that we cannot establish official relationships with A.A. but that we can use the experience and ideas of some members of the fellowship to broaden our own understanding. We must not lose sight of the effectiveness of Alcoholics Anonymous and we must utilize its help in treating these sick people.

And now we come to your newborn brother.

The Ohio Program

What lies ahead for the new State program? Will it blaze new trails into the woods to be followed by others or will it stumble around to be just another State agency supported by mediocre successes and stop-gap methods? How can the Columbus Area Council on Alcoholism help the State program? How can the State program help the council?

The first word of advice from your six-year old neighbor is this. Don't expect from the State program anything that you can do for yourself. Don't expect the State to take over the work you are now doing. We look on our State program as a wholesaler with local agencies doing the groundwork.

Your new State program has a small budget. Alcoholism is a big problem in Ohio or any other state. If your new baby brother tries to solve Ohio's alcoholism problem, it is doomed to failure. Its only hope is to use its resources to stimulate groups like your own to meet the problems on local levels. Here are some things that we are doing that may be suggestions for you to consider.

1. Each year about forty Michigan people attend schools of alcohol studies on scholarships awarded by our Board. This means that, all over the state, there are people interested in alcoholism and informed on alcoholism. This means that, all over the state, speakers are available to talk on alcoholism. All over the state there are physicians, and min-

isters, and teachers, and nurses, and psychologists, and law enforcement officers who are adapting their skills to the new knowledge about alcoholism in a way that makes them more effective in their daily jobs.

We send people to the four-week school at Yale and to the one-week Midwest Institute on Alcohol Studies. At the present time, the Midwest Institute is sponsored by alcoholism and educational agencies in Wisconsin and Michigan and it meets in alternate years in each state. I see no reasons why the new Ohio program could not become a full partner in the Midwest Institute and bring the session to your state every third year.

We also have a speakers' bureau that pays travel expenses and a small fee to Yale scholarship people who give talks on alcoholism. We have an annual Alumni conference to restimulate "graduates" of Yale and Midwest and to keep them up to date on what is going on.

Scholarships are investments in local level approaches to alcoholism.

2. The second activity that may be profitable for the State program is to help organizations like your own. We supply films, display material, publications, speakers, consultation services, research funds, grants-in-aid and special grants for educational programs.
3. A third area of activity is the fostering of an exchange of ideas and experience among local alcoholism programs throughout the state. We originally sponsored semi-annual sessions where we invited all the Michigan alcoholism programs to a workshop. This idea has evolved into a new organization called the Michigan Institute of Alcoholism Programs. We no longer finance the institute. We do not control it. We are members with equal rights and privileges. The Executive Director of our Board acts as secretary to the institute.
4. A fourth challenge to your new State program lies in the schools of professional education. Most law schools, and medical schools, and schools of social work, and teacher training institutions are not including instruction about alcohol and alcoholism in their curriculum. Many seminaries are giving degrees to young clergymen who are not ready to do pastoral counseling with alcoholics and their families. These institutions that train people in the helping professions should be encouraged to teach about alcoholism and its treatment. We do not brag about our success in these areas. We do have a good start in one medical school and in one teacher-training institution.

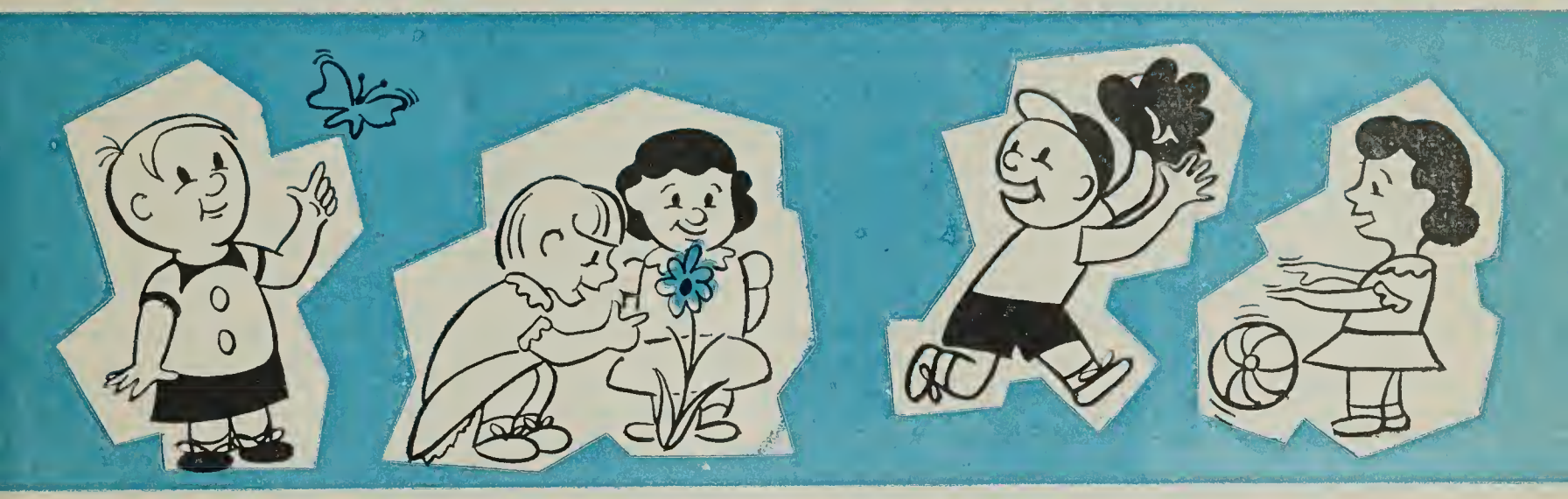
I could go on and on making these suggestions but I am not sure how valuable they are. The Ohio program must be tailored to Ohio's needs and resources.

I want to close with a brief summary. Three questions have been posed by your older brother. I have asked, "What do you want to be when you grow up?" and I have pointed out ten growing-up goals that we use. I tried to emphasize the importance of having long-range goals and the dangers in becoming too involved with today's problems.

My second question was, "How old are you?" and I suggested that we could not accept the new idea that alcoholism is an illness and still hold on to the old habit of blaming the

(Continued on Page 31)

The best sign that a child is mentally healthy is that he thinks, understands, and acts as a child.



READING THE SIGNS OF MENTAL HEALTH

By BRUNO BETTELHEIM

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WHEN we read or listen to what people have to say about this world of ours, we may get the uneasy feeling that they are mainly aware of what is *wrong* with us. The good things are so much taken for granted that they're sometimes overlooked. Sure, plenty is wrong with the way we raise our children. Sure, our educational system has its shortcomings. Still, we manage to have, by and large, a more intelligent citizenry than, for example, the Russian system of education produces. Sure, there is all too much corruption in politics. Still there is greater personal and individual freedom here than in any country I know. Sure, there is (as they say) a "neurotic personality of our time"; this is an "age of anxiety," neurosis, and unreason. Still, at many other times men didn't even know that they were neurotics or that theirs was an age of unreason and anxiety.

Maybe it is a good sign that we have been able to recognize and face our shortcomings. The person who realizes that he has emotional problems is in much better shape than the one with delusions of persecution or grandeur, who is convinced that his views of the world are correct. A knowledge of one's emotional difficulties may be a sign of relative mental health.

One reason why most experts write about mental illness rather than about mental health is that the more definite symptoms, such as fear of the dark, stealing, or bed wetting, refer to specific phases of living. It is more difficult to discuss mental health because mental health does

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not refer just to one area of behavior. Also, we can understand the significance of extreme conduct much more easily than we can understand actions that take place on a middle ground, between the extremes of behavior. For instance, it is quite easy to recognize as emotionally unbalanced a person who is always pessimistic and sees everything through dark-colored glasses. We are equally ready to realize that people who view the world only through rose-colored spectacles can be slightly off, too.

A Happy Medium

Human beings should be able to feel hot and bothered about some matters and indifferent about others. In either case they must be able to return from such excitement or indifference to a middle ground of balanced judgment, equanimity, and self-control. Mental health is being neither all the time hot nor all the time cold nor all the time lukewarm. It is rather the ability to have all these emotional reactions freely and none exclusively; to respond with each at the appropriate time and in the appropriate situation; and, most important of all, to return with ease from extreme reactions to the everyday, often unexciting tasks at hand.

But when is it appropriate to be excited and when to be indifferent? The answer changes with one's age. What is a matter of excitement to an adult is often a matter of truly Olympian indifference to a child, and the other way around. As every parent knows, a young child doesn't think it is important to come to the table with carefully scrubbed hands, not to mention his neck. The best we can expect is that he may feel indifferent about having to wash his hands.

If a four-or five-year-old, of his own accord, were deeply concerned about coming to the table with clean hands, I certainly would worry about him. I'd read his behavior as a danger signal rather than a sign of mental health. On the other hand, if his parents think it is terribly important that he wash his hands before sitting down to dinner, quite possibly he might wash to please them—though usually only if reminded. Maybe, to maintain his status as a good child, he might even occasionally wash them on his own! Yet that very indifference of his is a sign of mental health, as is his ability to get good and dirty without becoming too fearful about it.

As I have said, one sign of mental health is to be able to get excited about appropriate things and still be able to return with ease from such a state to the humdrum tasks of living. Hence a child reveals his mental health when he vociferously asserts that his dirty hands are "plenty clean" but then goes and washes them without being cross or sullen afterward. He shows he can get excited about what is exciting at his age, such as the need to affirm his own independence on matters of cleanliness, and still after a moment or two of screaming, proceed to compromise with his parents.

Signs Hard to Read

From this example parents may rightly conclude that it's quite a difficult and complex thing to read the signs of mental health correctly. First, they must be far enough away from their own concerns to realize that what they feel strongly about may be of great indifference to the child. Second, they must be aware of what is appropriate not only for the child to be indifferent about but also for him to get excited about.

To the adult an inexpensive toy is a trifle, easily exchangeable or replaceable. He usually expects the child to feel the same way, even to

the point of sharing it. To the young child, however, this toy may be the gem of his whole treasure house, without which life doesn't seem worthwhile. And if it is his most valued possession, we should expect him to feel and act just as we do about the things we cherish most (say, our bank balance). When a normal child is asked to give up or share his important toys he often reacts exactly as we would if we had to give up our stocks and bonds. If he does not, this may well be a serious sign of lack of relatedness or self-assertion in matters in which a child *should* be related and self-assertive.

Normal behavior in regard to the sharing of toys, then, would run something like this: First the child wishes to hold on to a toy. Later he realizes that by keeping it to himself he may lose a friend, so he reluctantly shares it—because human relations seem preferable to earthly possessions. After a while he may withdraw it again—because of a squabble or because his need for friendship has temporarily been satisfied. But if he's given his way, the satisfaction of possession will again wane, and he will once more be ready to give up or share the toy. And so it goes, over longer or shorter stretches of time.

Here again we see that mental health consists not of one type of behavior but of an easy moving back and forth between different and often opposite types of behavior. This analysis may offer little comfort to the parent who wants to settle things once and for all, who wants his child always to act "nice." Yet if we wish to safeguard our children's mental health we must be ready to follow them along their always oscillating way toward maturity.

Of course any youngster, after strongly asserting his own wishes, should be able to make some compromises with his parents without going to pieces. But if he spends most of his waking life being concerned with their interests instead of his own, this is no sign of mental health.

Other Examples

To continue with a few more examples that can help us assess children's emotional well-being: Healthy curiosity in a small child is certainly a good sign, but even curiosity differs widely with age, intelligence, and the child's past life experiences. I would be worried if a five-year-old were more curious about world peace or atomic war than about his spaceman's suit or what he is going to get on his next birthday. For a four-year-old to be curious about sex differences and to explore them is normal, and so are his efforts to deny their existence. But if he becomes so obsessed with differences between the sexes that he either cannot talk about them or talks of nothing else, then his curiosity is no longer a sign of emotional balance—rather the opposite.

To be afraid of the dark and what might lurk in it, or of having to sleep in a new place, is quite normal. Denying such fears might still leave the child in the mentally healthy group. Denial of dangerous and anxiety-creating situations at this age is a healthy device to make it possible for him to go on with the task of living and exploring. If, on the other hand, the child not only is afraid of the dark at night but remembers his fears in sunny daylight, then he surely is disturbed.

In general, the attention span of a young child is short, and he is easily distracted. During the day he is usually able to forget about what might have bothered him the night before. He laughs easily, cries easily; is

easily happy and easily disappointed; and most of all, he is fickle. He will, for example, spend some time persistently trying to tie his shoes "by myself." He insists he can do it—then suddenly gives up and turns to his mother, saying "You can tie it."

This ease of movement from one attitude or desire to another, from utter and often unreasonable self-assertion to complete dependency, is a sign of mental health. The opposite attitude—not being able to be flexible, being always either dependent or self-assertive—may point to a serious emotional disturbance. Obviously, as the child grows older, he will learn to stick to a task, make lasting commitments, and develop permanent attitudes. These will be signs of mental health in the adult, as is the ready shift from happiness to unhappiness, from serious self-application to "let the other guy do it" in the child.

Appropriate Emotions

Another pretty definite sign, one that can be readily observed and does not change with age is the ability to have and show the appropriate emotions. A grownup will be upset about losing a job, a child about losing a game. But a youngster who doesn't get excited on his birthday or upset about losing a game does not have at his disposal the full richness and range of emotions that reveal mental health.

And speaking of games, we adults might bear in mind that to the five- or six-year-old, winning or losing in a game is very important. In fact it is so important that he usually makes an effort to correct his luck by cheating, modifying rules in his favor, or insisting that he won when he lost. At this age a child just can't be a good loser. If he is able to lose without any ado, then either his conscience is overly strict or he has a need to be punished or he feels defeated even before he starts.

Here, then, is another territory in which the signs of mental health are clear but often difficult for an adult to read correctly. We are too inclined to evaluate behavior in terms of our own standards rather than the child's stage of development. Parents who read in Gesell about the typical behavior of children of certain ages are often astonished at how long it takes some behavior to develop. A youngster's ability to obey rules comes relatively late in childhood, and it takes him many years really to understand them.

Though losing in a game is a major adversity to a preschool child, there are other, more serious adversities in his life, and in all but the most serious of them he should derive comfort from his favorite toys. A doll or a stuffed animal is a tangible symbol of security. His need for it will be greater in times of serious stress or radical change.

Good Sign

It's a good sign, therefore, if he clings to his prized possessions and gains comfort from them when moving to a new home. But if a four- or five-year-old is not upset about leaving his old home or moving from one nursery school or kindergarten to another, it is emotional isolation, not good adjustment, that permits him to take such an upheaval in his stride. And if a youngster cannot form new ties in his new environment, he lacks the flexibility in forming new relations, that is a sign of mental health.

Thus we see that one of the best signs of mental health is that a child can feel deeply significant events yet recover his emotional balance in due time. After a lost game he must be able to regain his emotional balance within a few minutes; after a move to a new home, within a few weeks

or months; and even after the loss of a parent, within a few years.

This ability to feel strongly and still be able to regain balance extends to all areas of living. For example, it is normal for a young child to want nearly all the toys he sees pictured in a catalogue or to ask for half a toy store for Christmas. But if, come Christmas, he is delighted with a small, appropriate selection, he's mentally healthy—like the six-year-old who said, "I didn't get all the presents I wanted, but it was the best Christmas ever." Probably the surest sign of his mental health was his ability to tell his parents of his dissatisfaction and his pleasure.

To be able to talk about what's on his mind, what worries him, what he wants or is afraid of, and also to make honest statements about his feelings, is normal for a young child. So, too, is his ability to evaluate others on the basis of his standards rather than ours. Let's face it. There are some very nice people who are tense or critical with children. It's a sign of mental health when a child can say about such a person "I don't *want* to visit him," even if it should happen to be a grandparent!

We cannot say with any certainty that to be shy with strangers or to go out to them wholeheartedly is another sign of mental health. Some children are so busy with their play that they care little about others. But it is true that the mentally healthy child is able to assess how welcome or unwelcome his behavior is and, with it, how welcome or unwelcome he himself is.

To sum up: It is a good sign of mental health if a child, after a short period of experimentation and exploration, can read correctly the signals derived from his environment and respond to them appropriately. With rare exceptions, of course, the normal child will not love people whom his parents dislike. If he does, either his relations with his parents are bad or he is not mentally healthy. Nor is the child who does not become anxious or disturbed when his parents are upset, or who cannot or will not share their happiness. Allow me to close with a quotation from the Bible: "When I was a child, I spake as a child, I understood as a child, I thought as a child." Maybe this is the best of all signs of mental health: that a child speak, understand, think, and act as a child, not as a poor imitation of an adult.

MENTAL HEALTH PARADOXES

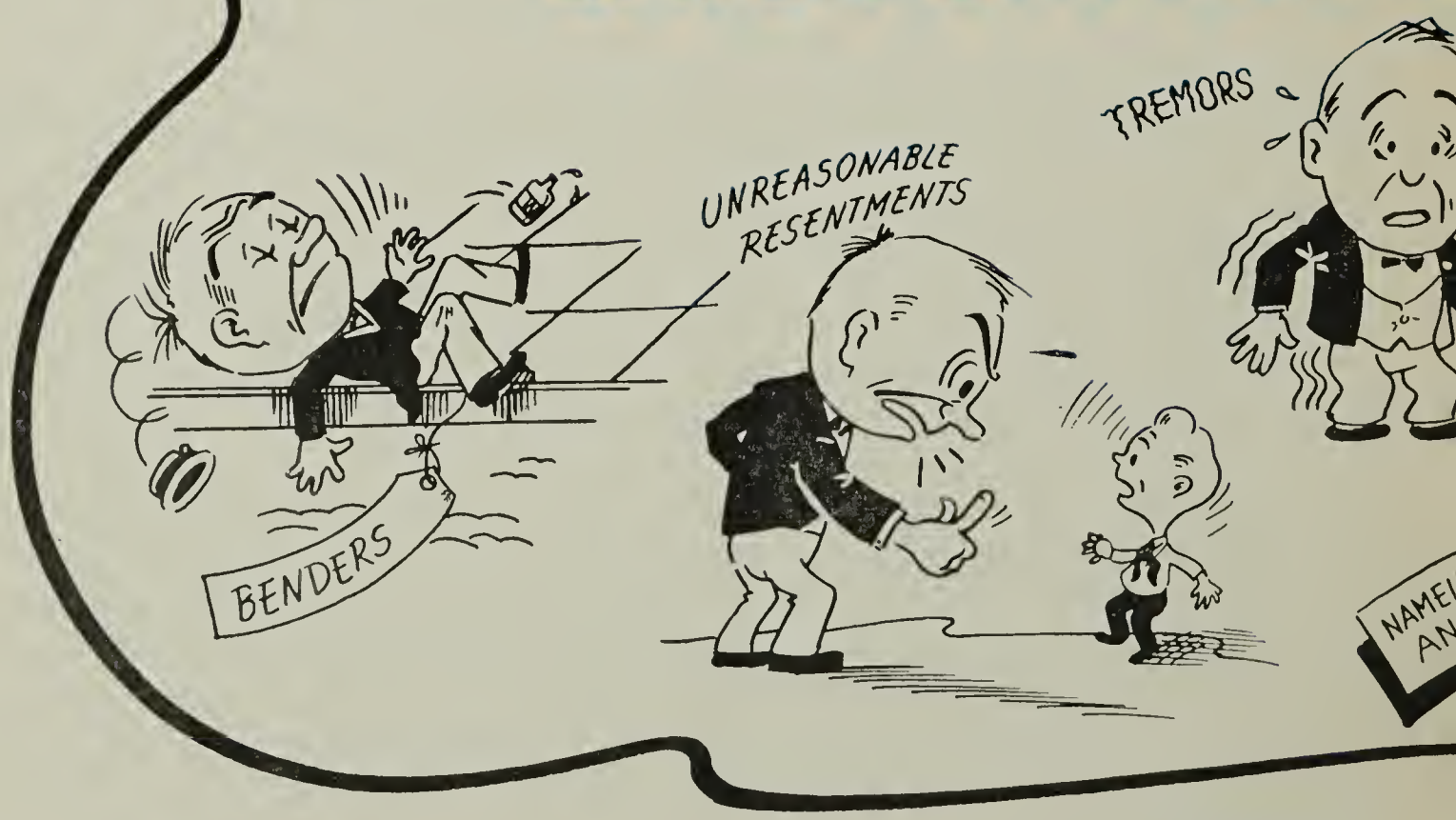
MENTAL health requires movement by any person toward individuation, toward becoming his own distinctive and individual self. At the same time, there are standards for and limits to this process, and mental health can be achieved only by an honest acceptance of these standards and limits.

MENTAL health involves development of the basic capacity to love, to achieve the strength for relatedness to other human beings. At the same time, an advance toward mental health is a movement away from dependency and toward personal independence and self-responsibility.

—The Rev. Seward Hiltner
in the Menninger Quarterly

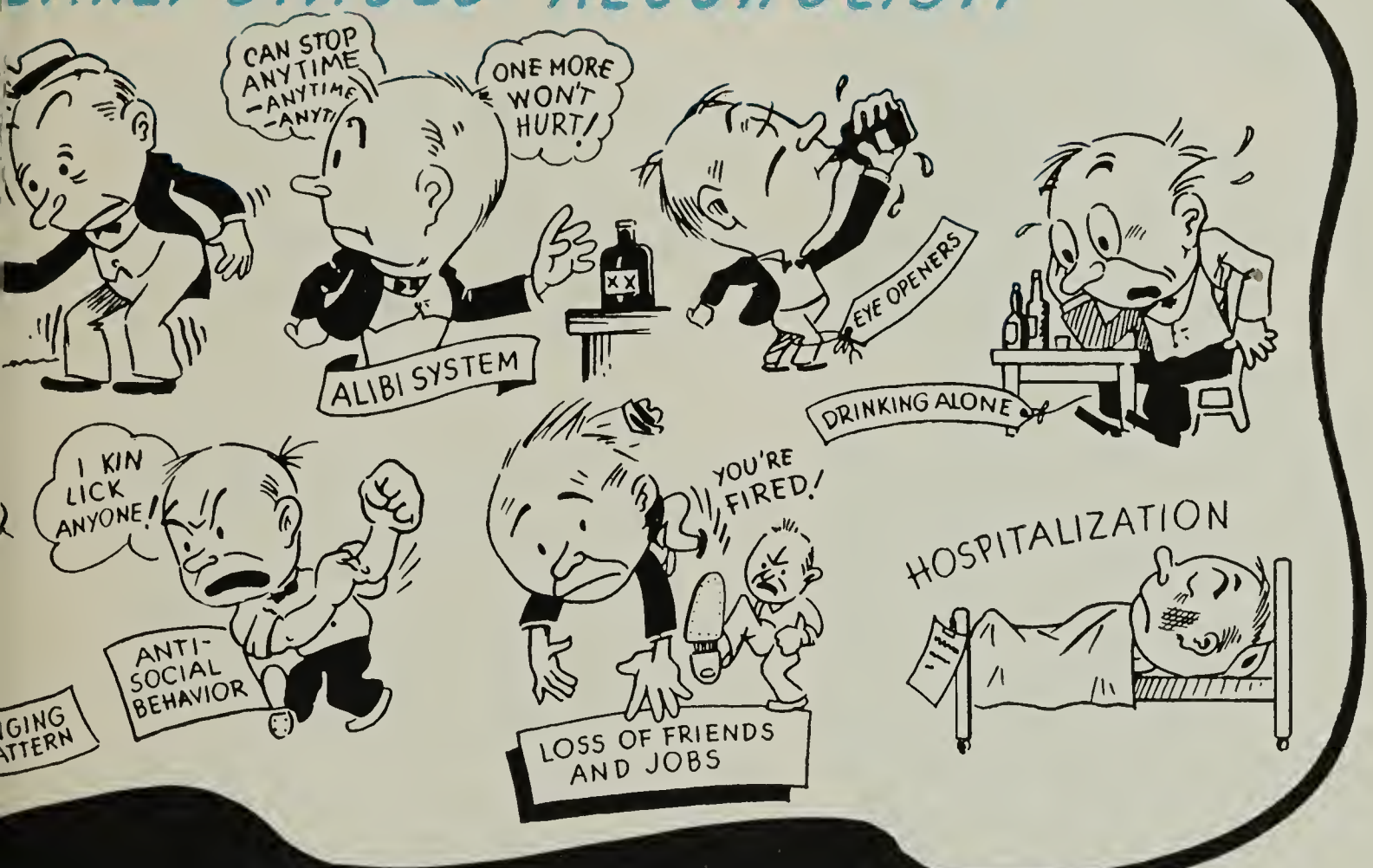
PROGRESSIVE SYMPTOM

LATER STAGES A

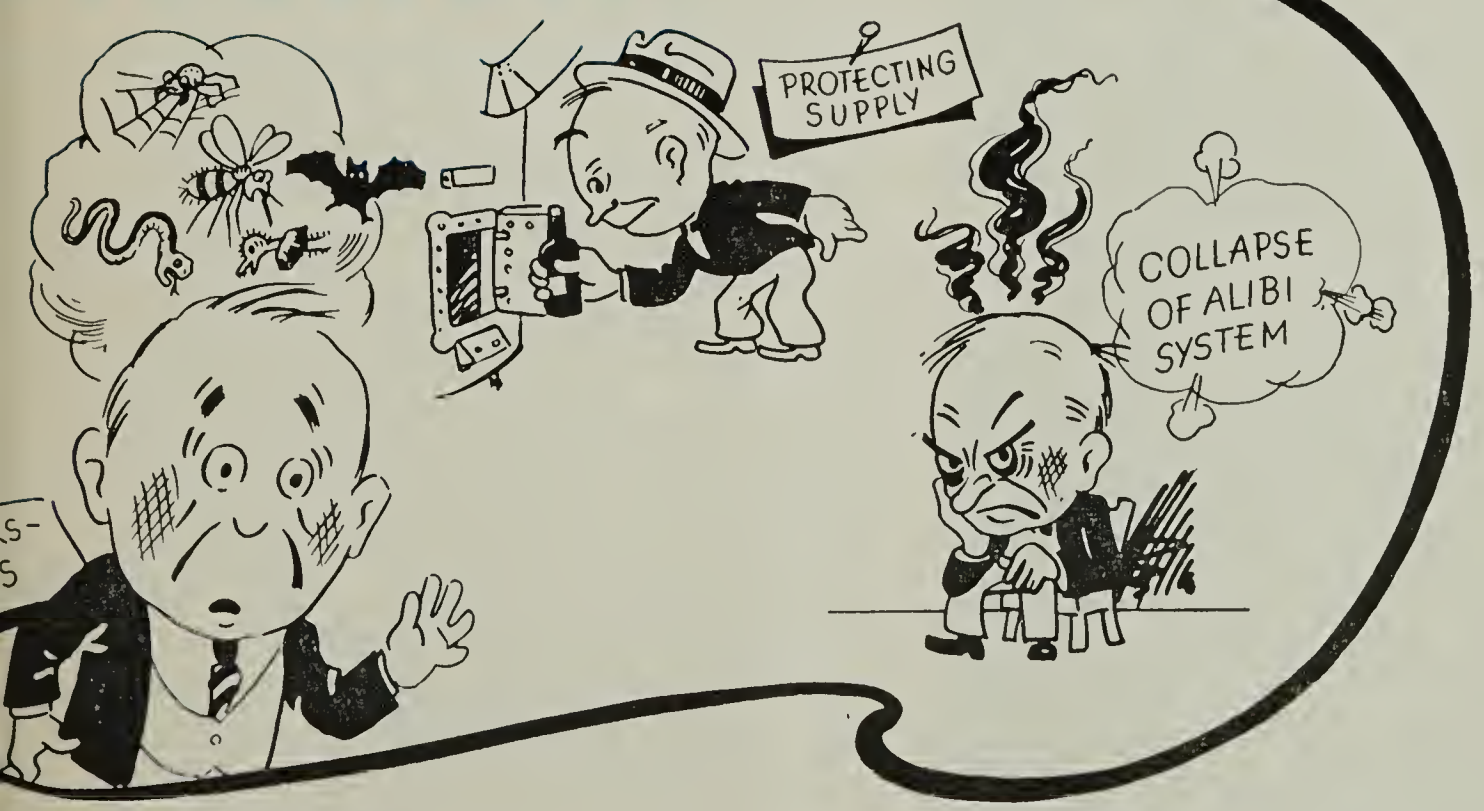


OF ALCOHOLISM

EARLY STAGES ALCOHOLISM



COHOLISM



THE CHRONIC

A study of inmates in a county jail in New York reveals the serious social problem presented by those inebriates for whom the door of the jail is a revolving one.

"OVER a million arrests are made in the United States every year on the charge of public intoxication or drunkenness. An enormous number of these actions involve the repeated arrest of the same men. The chronic police case inebriates are the men who are arrested, convicted, sentenced, jailed, and released, only to be rearrested—often within hours or days. They are the men for whom the door of the jail is truly a revolving door. They are the men who inhabit Skid Row found in every large city."

Given present-day social and cultural definitions and philosophy as they are represented in the law, the individual who is convicted of public intoxication or a related offense must be punished for his deviant behavior, although many judges use every means at their disposal to avoid imprisonment until treatment methods available in the community have been exhausted. Community attitudes, however, define the public inebriate as a nuisance who must be either fined or jailed. Some segments of the community seem to feel that punishment by incarceration or a stiff monetary penalty will induce the individual to change his style of living and way of life; that in the

POLICE CASE INEBRIATE

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penitentiary he will grow penitent of his "sins" and become a sober member of the community on his release.

The results of our investigation negate completely the assumption that incarceration acts as a deterrent to the chronic public inebriate. Let us see just how successful jailing has been in preventing these men from resorting to drunkenness. Of the 1,357 men committed to the Monroe County Penitentiary in 1954 on charges of public intoxication or allied offenses, only 5 were newcomers to prison life. About one-third of these men—455 to be exact—were there for their second to tenth round. Nearly 6 out of 10 (801) men had been committed from 10 to 25 times to a penal institution, and 96 men had served 25 or more jail terms. Our study group, a random sample of their kind, includes men who have been arrested 81, 90 and 110 times for public intoxication. There is no question about it: jailing has not deterred them from further public drunkenness.

In brief, these men are not rehabilitated in the penal institution. Any belief that punishing them by a jail term in the county penitentiary will help solve their problem is an illusion. It must be recognized that repeated jailing, as a socially and legally accepted philosophy in the community for reforming the chronic inebriate, has been and will continue to be a failure—aptly termed the revolving door policy—unless radical changes are instituted by the society.

In the jails of the nation the present emphasis is upon custodial care rather than rehabilitation of the public inebriate. Our investigation indicated that many of these men could be rehabilitated if treatment were available to them as part of an integrated program. In the present penitentiary system some men do not even receive systematic medical examinations to determine their physical condition and what essential physical treatments and corrections are required. There is no legitimate excuse for the incarceration of the tubercular alcoholic; his place is in the sanitorium. Some steps are now being taken to correct this in Rochester and elsewhere. Those who are mentally ill belong in the state hospitals. The paucity of psychiatric service makes any effective mental health care unavailable to this group. Rarely is there an assessment by a competent individual, such as a social worker, which might help de-

termine what assets an individual has for rehabilitation and allow the development of a classification scheme for handling various types of offenders.

Release procedure that would aid in the inebriate's subsequent community adjustment is nonexistent. This is in sharp contrast with the practice in releasing prisoners convicted of felonies in New York State. A system of parole planning reduces the risks of unemployment or homelessness. But the more numerous short-term misdemeanants, upon release, are provided with little more than fare to the county seat or to the city from which they were sentenced. There is almost complete absence of systematic parole planning which would include the location of employment and a residence and provision of essentials for living at least until the first pay is earned. Is it any surprise, therefore, that the inebriate is often arrested for public intoxication within 24 to 48 hours after his release? Thus the vicious circle is retrodden, culminating in the institutionalized offender—one who develops a social and psychological dependency on the institution and begins to view it as his home.

Newer Philosophy Needed

The present indictment of the system of incarcerating the chronic police case inebriates is of course not a criticism of the officials of the penitentiary where this study was conducted. The personnel of this institution are doing the best job possible, given present public attitudes concerning the public inebriate. They are only performing the functions society has created, and this applies to the staffs of many like institutions throughout the land. Our observations are directed against the philosophy of handling the chronic inebriate, not the personnel assigned this duty.

Our treatment of the chronic inebriate reflects long-established customs, moral sentiments and legal rules of our society. They are rooted in a centuries-old philosophy which regarded drunkenness primarily as a moral problem. This belief has resulted in handling the inebriate according to practices which are at least a century behind those employed in other fields of social welfare. The newer concept of alcoholism as a social, mental and physical illness is in gross conflict with punishment and confinement for the habitual public inebriate.

Recommendations

1. *New Approach.* Given the failure of the present system to cope with the problem of the chronic police case inebriate, a new system or philosophy should be envisioned built on the concept of treatment and rehabilitation instead of punishment and custodial care. The present system hardly does more than allow the inmate to build up his physical resources for a new drinking bout upon his release and then to lapse back into the hands of the police.

2. *A Treatment Center* should be created for the reception of the chronic public inebriate. This means that they should be removed from the jails and penal institutions as the mentally ill in this country were removed from the jails during the last century. Given the present state of knowledge concerning alcoholism, the time is ripe now for such a change. The present system is not only inefficient in terms of the excessive cost of jailing an offender 30, 40 or 50 times, but is a direct negation of this society's humanitarian philosophy toward people who are beset by social, mental and physical problems.

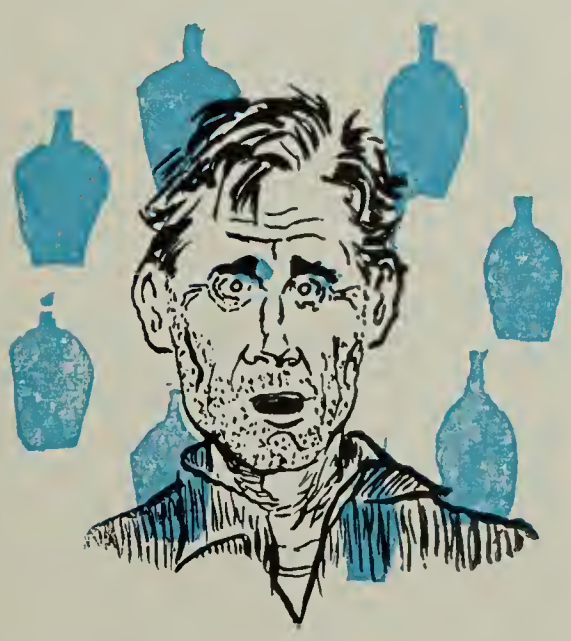
3. *Systematic Treatment* has not

been tried as a method of dealing with the problems of excessive drinking of over 90 per cent of these men. The following are essential factors in the operation of any treatment-rehabilitation center:

A. *Medical and physical rehabilitation:* Some prisoners are sick with tuberculosis, venereal disease, hemorrhoids or other physical maladies. This investigation has shown that after necessary minor and major physical corrections at least 80 per cent of these men are employable at some task.

B. *Psychological rehabilitation*: Both psychiatric and psychological evaluations are essential to determine the internal resources of the individual for meeting external reality. Psychotics should be sent to their proper place in mental hospitals. For the majority, therapeutic devices can be instituted, such as group therapy and individual counseling.

C. *Social rehabilitation*: The present system does little for the social rehabilitation of the inebriate during the period of incarceration. The treatment center with an accent on rehabilitation can be the group context within which the individual gains insight and develops new solutions to his problems. A social worker can record a case history of the inebriate in which assets for rehabilitation are evaluated and an individual plan for rehabilitation is prescribed. For those who are interested, Alcoholics Anonymous groups should be encouraged, and occupational therapy should be provided for those who can benefit.



4. *Release Procedure*. Release from the treatment center should be based on a system of parole planning in which each individual participates in a plan of recovery.

A. *Social Work*: In the treatment of mental illness, convalescent care or parole planning has become an important part of release procedure. In the treatment center for inebriates a social worker can provide the focus around which a systematic plan is worked out for the release of each man to society. The plan should include provision of a job, housing and financial aid until first wages are received, and contact with community resources such as Alcoholics Anonymous, clinic facilities and other social agencies.

B. *Halfway House*: For those whose histories show a confirmed pattern of dependence upon institutional living, release to independent living may only be a gradual process. For the excessively dependent person the "halfway" house advanced as a therapeutic device by students in this field would be a useful part of the program. A sudden complete severance from the treatment center would be traumatic for some. The "halfway" house cushions the shock of the movement from slavish dependency by providing supportive independence in the form of a residence in the city to which they can return after work, where they can take their meals, and par-

ticipate in some forms of recreation and social living. The pattern of dependency is so deeply ingrained in some men after 30 or 40 years that they may never advance beyond this stage; but they may at least be made economically self-supporting.

5. *Differentiation of Types.* There are several different types of men among the chronic police case inebriates who will require different kinds of treatment. This can be discerned from adequate social histories which are part of the intake procedure of a treatment center. These social histories will allow the development of a system of classification which will be useful to all personnel engaged in the work of rehabilitation.

A. *The Negro*: Negroes are migrating to various urban centers in growing numbers. Our study shows that, given present conditions, greatly increased numbers of Negroes will fill the city jails on conviction for public intoxication. These numbers can be reduced substantially if each community will develop a policy of aiding the less advantaged Negro migrants. Most communities are without such a policy, and Negroes in general are relegated to the slums and blighted areas of the city. They need constructive programs now, rather than platitudes about brotherhood. There should be specific education programs for all public officials and private agencies on the special problems of the southern rural Negroes who migrate to the North or West. As all previous studies in this field have shown, the Negro is the victim of discriminatory treatment in arrest and commitment. Eighteen per cent of the men in our sample were Negro, compared to 2 per cent Negroes in the county populations—a reflection partly of the higher vulnerability of the Negro to police and court action.

B. *The older offender* with few arrests for public intoxication and no other history of criminal involvement (one of the "Late Skid" types): The major problem here is physical decline which affects occupational abilities; the drinking problem may be secondary. Special consideration must be given to the dependency needs of these individuals. Certain institutions, such as the County Home, are now available for this type, but the way of life of these men is so incompatible with this sort of institution that they cannot adjust to it. The special problem of relating this type of individual to an institution should be reexamined. Our study shows these men are highly amenable to institutional living but not suited to many of the existent institutions. The Men's Service Center in Rochester, New York, has had considerable success in removing many of the negative features of institutional living for this type of man. This group also needs special attention for physical maladies due to aging.

C. *The mentally disturbed*: For men, especially in the younger age brackets, with psychological disturbances as mainfested in their social and criminal histories, deep-going psychotherapy is indicated. Their histories show, however, that the disturbances were frequently noticeable in the childhood or adolescent phases of their personality development. Mental hygiene in early life is still the best means of coping with behavior disorders.

6. *Research.* A program of continuous research in the problem area of alcoholism, within which the chronic police case inebriate is only one part, is essential. We hope that state and community agencies will be able to utilize this study in formulating basic policies for rehabilitation of these inebriates. We suggest here only a few of the many research topics which have been engendered in the course of this investigation.

A. Systematic evaluation of the results of the different measures now being tried for the rehabilitation of the chronic police case inebriate and the general category of alcoholics should be expanded.

B. Research should not be confined to a study of individuals who have developed the pattern of excessive drinking or alcoholism. Our interests should reach beyond merely salvaging and repairing individuals who have serious problems, although this is a necessary activity. Research is indicated to obtain an understanding of the deep-seated origins of the behavior disorder, particularly in two areas:

(a) *Adolescence:* One hypothesis that might be tested is that the socially isolated adolescents of lower-class Irish background and lower-class background of certain Protestant groups have a greater chance of becoming chronic police case inebriates than do adolescents who are not members of these groups and who are incorporated into clique groups.
(b) *Institutional living*: The role of institutional living contexts in initiating and supporting excessive drinking warrants investigation.

7. *Conclusion.* We recommend that the program of treatment take into account the realities of status and life circumstance which brought the chronic police case inebriate to his present condition. Our study has shown him to be the product of a limited social environment and a man who never attained more than a minimum of integration in society. He is and has always been at the bottom of the social and economic ladder: he is isolated, uprooted, unattached, disorganized, and homeless, and it is in this context that he drinks to excess. As such, admittedly through his own behavior, he is the least respected member of the community and his treatment by the community has at best been negative and expedient. He never attained, or has lost, the necessary respect and sense of human dignity on which any successful program of treatment and rehabilitation must be based. He is captive in a sequence of lack of loss of self-esteem, producing behavior which causes him to be further disesteemed. Unless this cycle is partially reversed, we doubt that any positive results can be attained.

Treatment Program

A program of treatment must strike at his dependency needs and recognize his needs for human approval and self-respect. The program must therefore be administered by persons who are professionally competent to minister to his needs, who can create an environment of human warmth, and who are personally interested in the inebriate as a human worthy of respect. Within such a context the goals for rehabilitation must be realistic. We may eventually find that the rehabilitation of only a majority of this group is a notable achievement. Even so, if the remaining minority are simply maintained according to standards consistent with morality and decency in our time, it will do credit to the community which first makes such a contribution.

INTO THE LIGHT

A television series produced by the ARP attempts to shed some light on alcoholism.

THE second hand crept slowly around the face of the clock. One could sense the feeling of anticipation among the persons in the large room. At last it was 8:30. It was time to begin. A camera, its red lights aglow, focused on the silhouette of a man. The announcer's voice sounded over the speaker in the studio: "The steps a man takes from alcoholism to sobriety are the steps from darkness into the light." The music swelled, the lights came on and a man began to speak: "Good evening, ladies and gentlemen. The North Carolina Alcoholic Rehabilitation Program is pleased to bring you another in its series of programs on alcoholism."

This is the scene in the studios of WUNC-TV, the University of North Carolina's educational television station, every Tuesday night at 8:30 when "Into the Light" goes on the air. Back in the Fall, the station's program director, Hank Cheney, told the ARP staff that he would like for them to produce a series of thirteen half-hour programs on alcoholism. The programs would run from February 9 through May 6. The staff liked the idea, but it was hard to conceive of doing so *many* programs. It would be a big undertaking. However, it was felt that this would be a good opportunity to help promote increased public understanding of the illness which today affects more than five million Americans.

And so, the ARP began preparations for its television debut. The subject of alcoholism is a complicated one, and obviously it would be impossible to include, even in a series of this length, everything there is to say about this illness. So the task began of surveying and narrowing down the subject matter to a few select topics. Members of the staff selected material which they considered to be of most importance and interest to the viewing audience. Such topics as the prevention, causes, symptoms, and treatment of alcoholism; the personal experiences

of an anonymous alcoholic; the effect of alcohol on the human body; community resources which can provide help for the alcoholic; contributions which the school and the church can make toward helping persons afflicted with alcoholism; and a panel discussion on mental health were chosen for presentation.

Now the staff was faced with the problem of locating some persons in the community who might serve as panelists on "Into the Light." Besides leaders in the Raleigh area, efforts were made to interest persons throughout the State to appear on certain programs. Physicians, ministers, businessmen, and educators, among others, agreed to help out, and together with Mr. Cheney and his staff at WUNC-TV, have given very generously of their time to make this series a success.

Some of those persons who have appeared and who will appear in future weeks as panelists include: Dr.

Eugene Hargrove, North Carolina Commissioner of Mental Health; Dr. Donald Macdonald, Medical Director of the ARP; Dr. Fred Ellis, Professor of Pharmacology in the University of North Carolina School of Pharmacy; Dr. John Ewing, Associate Professor of Psychiatry in the University of North Carolina School of Medicine; Miss Roberta Lytle, Psychiatric Social Work Consultant and Miss Janet Haas, Psychologist, both of the Butner Treatment Center; Judge Mason Thomas, Reverend Lynn Brown, and Mr. Haslin Simon, all of Raleigh; Dr. Thomas Jones, Durham physician and president of the Durham Council on Alcoholism; Mr. David Godfrey of the North Carolina Prison Department; Reverend Joseph Kellermann, Director of the Charlotte Council on Alcoholism; Mr. Worth Williams, Executive Secretary of the Greensboro Council on Alcoholism; and Reverend Edward Laffman, Director of the Vance County Program on Alcoholism.

The moderator of "Into the Light" series is ARP Educational Director George Adams. Mr. Adams had been on television before, but had never participated to the extent of serving in this particular capacity. As the day of the first show rolled around, he began to feel a bit nervous. He wondered if the questions he was going to ask the panel members were all right. What would happen if they ran out of time? And would he be able to wind the show up on schedule?

Sensing that the ARP moderator needed some encouragement, on the day when the series was to be premiered the staff presented him with a gigantic capsule, on which was the neatly typed prescription: "To be taken every Tuesday night at 8:30." Inside were thirteen aspirins. This gesture must have done the trick, for each program has come off without a serious mishap.

However, there are few television productions which ever conclude without a hitch of *some* sort, and "Into the Light" is no exception! Some of the "bloopers" which occurred behind the scenes, probably unknown to the viewing audience, make humorous stories. For one recent telecast it was necessary to prerecord the voices of several people to supplement a particular item of art work that would be shown on that evening's show. The ARP staff, together with some voices "borrowed" from a neighboring office, made the tape. That evening found the "voices" in front of their television sets awaiting their big moment. All that greeted them, however, was dead air. As a result of some unknown technical difficulty, the voices were never heard!

Good Response

"Into the Light" is one of the few television series on alcoholism to be produced in this area of the country. The ARP staff is grateful for the opportunity to present via the medium of television this series of programs. Results of the telecasts have been most gratifying, and it has been reported that a number of Alcoholics Anonymous groups throughout the state have been centering their meetings around the "Into the Light" series.

There is an ever increasing need for alcoholism education in our country, as this is an illness which has become a serious health problem having far-reaching complications. Education is certainly one means by which it can be prevented. It is hoped that those groups and organizations whose primary function is aiding in the prevention and treatment of alcoholism will take up the challenge which awaits them. It is not one we can afford to pass by. (*J. R.*)

Understanding The Alcoholic

By DONALD W. HEWITT, M.D.

The physician's role in treating the alcoholic is unique.

IF a nation-wide poll were to be taken today on the general public's reaction to alcoholism and, more particularly, to the alcoholic, I think it would be found that the majority of laymen consider the alcoholic a weak, shiftless character who doesn't possess sufficient will power to stop drinking, or who drinks out of pure "orneriness" and a sadistic desire to make other people suffer.

Unfortunately for the alcoholic, surface appearances of his condition appear to corroborate this adverse diagnosis, and we find that quite a few general practitioners also subscribe to this point of view, either wholly or in part. It must be admitted, some practitioners consider the time and effort spent on the treatment of alcoholics as a total loss, and they make no effort to hide the fact that they do not wish to have such persons as patients. This feeling is not without cause.

Perhaps such unsympathetic members of the medical profession would be stimulated to change their attudes, if they realized that these alcoholic men and women are often

From ALCOHOLISM—A TREATMENT GUIDE FOR GENERAL PRACTITIONERS, Lea & Febiger, 1957

desperately sick individuals who have reached such an impasse through their uncontrollable drinking that they can see no possible way out of their dilemma and, consequently are either consciously or subconsciously toying with the thought of self-destruction.

The sympathetic and open-minded general practitioner who conscientiously does his best to help the alcoholic overcome his destructive habit, will find himself admittedly confronted with a complex problem that requires the best of his talents, patience and energy to solve. If he expends these wisely and well, he is likely to experience the deep-seated satisfaction that comes from seeing a miserable, hopeless, dissatisfied individual regain his interest in a community that had previously written him off as a total loss. In such instances, the general practitioner is apt to feel that he has been amply repaid for the time and effort he has expended.

Any doctor who has ever treated alcoholics knows that the typical alcoholic has usually encumbered himself with one or more highly undesirable personality traits in the course of his drinking career. True, many of these adverse traits may have existed in an undeveloped, embryonic state from his early childhood, but equally true is the fact that they have been developed and brought to full fruition through his growing alcoholism.

Among the more commonly encountered adverse personality traits found in alcoholics is their common tendency to develop deep-seated and g r e a t l y exaggerated resentments from the most trivial of causes, sometimes even from no apparent cause at all.

All of us, of course, experience a variety of resentments in our daily lives. But what distinguishes the alcoholic from the nonalcoholic in this respect is his abnormal reaction to such situations. His resentments become deep-seated and perhaps even obsessive in nature. He worries a great deal about them and this in spite of the fact already mentioned that they are in many instances either exaggerated or imaginary.

Out of Proportion

While the non-alcoholic will generally acknowledge his resentments, seek to analyze their validity and dispose of them in some legal and commonsense fashion, the typical alcoholic will, instead, nurse and nurture them until they have developed out of all recognizable proportion to their real importance. Such a process, of course, results in the development of a sense of self-pity and aggrievement that is often fatal to continued sobriety. The alcoholic soon feels that he has been sorely misused and imposed upon, and, as his sense of rank injustice grows, so does his need for consolation. When this is lacking from his wife, family or friends, he will often turn to the corner saloon for solace. He knows that here he is assured of a ready ear for his troubles just as long as he continues to buy drinks. The average bartender's sympathy, it would seem, corresponds almost exactly with the amount of money the patron is willing and ready to spend over the counter!

Of course, the nurturing of such resentments in a person's life—whether he be an alcoholic or not—is inimical to the attainment or retention of peace of mind or any appreciable degree of serenity. In the case of the alcoholic, they constitute an insurmountable barrier to sobriety that must be removed before any real progress can be made toward lasting recovery.

The obsessive nature of many al-

coholics' resentments is of such an intense and unreasoning sort as to suggest an abnormal mental condition not much unlike actual paranoia.

The first step for the general practitioner, therefore, is very likely to be an effort to uncover the alcoholic patient's resentful feelings and then to explain them in terms that will help the patient to relegate them to the background where they rightfully belong.

A common source of resentment in an alcoholic is an unreasoning and often unfounded fear or hatred of his boss. When this manifestation is traced to its source, it is quite commonly found to arise from the patient's intolerance for all authority and his deep-seated hatred of anyone who makes him do something against his will. As his mistrust and suspicions grow, this resentment may even extend to his wife and friends, until he may imagine that they are plotting individually and collectively to thwart his desires and impose their wills upon him.

The sad part about this situation is that, once these strong alcoholic personality traits develop and become closely allied to delusional symptoms, the alcoholic himself is virtually powerless to combat them. He *must* have outside aid to overcome them or he will progress not only to inevitable destruction of himself but, very possibly, of his loved ones also.

Sense of Remorse

Another complicating trait common to most alcoholics and excessive drinkers is a deep-seated, agonizing sense of remorse that torments them in the wake of their drinking sprees. Some degree of this pathological state is undoubtedly due to the inherently depressant nature of the alcohol they have been consuming. Part of it is a result of the vitamin- and mineral-deficient diet on which they have been subsisting during their alcoholic debauch. And a third factor is quite probably a guilt complex that has developed as they begin to realize the worry, suffering, and hardship they have brought to others through their drinking.

Many alcoholics, when they have sobered up and are confronted with the eccentric, sometimes antisocial, things they did while they were drinking, are aghast that they could have been induced to such behavior and, unless watched carefully, may decide to blot out such a distasteful reality by a return to drinking.

Such a course may provide them with a temporary respite to their problem and some measure of transient relief from the tensions that have built up, but in the long run it will almost surely serve merely to compound their troubles and add to an already well-nigh intolerable situation.

The general practitioner who finds his alcoholic patient in such a remorseful frame of mind can turn it to good advantage, if he will seize the opportunity to prove that he is a sincere friend who has the patient's welfare and best interests uppermost and who is interested primarily in helping the alcoholic recover from his destructive habit. The doctor should make this the occasion also to fortify the patient's wavering courage and hopefulness for ultimate victory over his vice. He must talk courage to him and help him rebuild the faith that has been so rudely shattered so many times by his repeated alcoholic "slips."

Many alcoholics, the general practitioner will also discover, are plagued constantly with more or less deep seated feelings of guilt, insecurity and inadequacy. These may stem from as far back as infancy or they may be of comparatively recent ori-

gin. But in either case, they must be treated sympathetically and intelligently before any real hope of returning the patient to lasting sobriety can be realized.

Often a sense of inferiority may be of a sociological or sexual nature and will require patient encouragement to bring it out into the open where it can be treated successfully.

A haunting fear of being unable to meet successfully job requirements or responsibilities; a similar conviction that he is unfitted to earn a livelihood for his wife and growing family, or to meet his financial obligations—any one or all of these often groundless but, to the alcoholic, very real crises—may be all that is needed to plunge him once more into the maelstrom of uncontrolled drinking that will, of course, bring his dire predictions that much closer to reality.

At this stage, the alcoholic requires the constant reassurances of his wife and family physician in order to bolster his faltering ego and his wavering faith in his own capabilities. His assets, however nebulous these may be, should be stressed and his weaknesses and failings similarly minimized to bolster his battered self-esteem.

But, in the case of the alcoholic, similar headlong impetuousness is quite likely to cause him an unpredictable amount of trouble. The alcoholic wants that raise of the promotion he feels is due him *right now,* not when the boss figures it's due; he wants that well-paid position or that new car or that new house with like imperativeness and, unless he gets them, he is likely to stage the equivalent of a childish "tantrum" and then, more often than not, to seek consolation where he has so often found it in the past—in the bottle.

It is necessary, therefore, that the general practitioner teach the alcoholic painstakingly all over again the childhood lesson of patience and tolerance he has discarded somewhere along the way. He must be shown kindly but firmly that *his* wishes and *his* desires are not, by any means, the most important consideration in the world and that they must quite often be subordinated to the best interests of those around him.

As might be expected, many alcoholics will be encountered who have as their chief ambition and goal in life, the accumulation of wealth, the attainment of a position of social or political influence, or a post where their views and opinions are eagerly sought and where their self-esteem is constantly being bolstered by the adulation of others.

Having set their hearts and souls upon the attainment of such purely materialistic goals, the alcoholic is prone to overlook the fact that many of them are beyond his reach. His failure to attain his fondest desires comes as a thorough shock to him therefore, in such instances and, in his frustration and deep-seated sense of personal failure, he is very apt to turn again to alcohol for consolation.

Another unique characteristic possessed by many alcoholics is their tendency to overdo everything they undertake. If they smoke, they usually do so excessively; if they drink coffee, they likewise go far beyond the limits of moderation (15 to 25 cups a day sometimes); in their work and play activities alike, they are apt to be "drivers," who push themselves to the limits of physical and mental endurance with ill-concealed impatience of all restraint. As a result of this punishing technique, many alcoholics sooner or later find themselves physically, mentally and nervously bankrupt and resort, in some instances, to the use of barbiturates or, in other cases, to their opposite—such substances as Benze-

drine to "keep them going." Sooner or later, of course, there is bound to be a crack-up and, unless adequate safeguards are taken, the patient will relapse again into his old disastrous drinking habits.

The general practitioner will also almost inevitably encounter a considerable number of alcoholics who stubbornly cling to the entirely erroneous impression that some day, somehow they are going to be able to be "social" drinkers as they once were before alcoholism overtook them. Unless entirely disabused of this dangerous notion, these individuals are heading straight back to the alcoholic misery and degradation from which they have so recently emerged. The general practitioner should take great pains to stress the fact that any alcoholic indulgence or experimentation, *including* the sampling of the apparently innocuous glass of beer or wine, is strictly "out" so far as the alcoholic is concerned. In other words, the alcoholic must learn sooner or later to adapt himself to a new way of life in which alcohol is conspicuous by its absence.

The adverse personality traits I have mentioned are some of the principal, but by no means the sole ones that the general practitioner is likely to encounter in his treatment of the victims of alcoholism. There are many others, but their incidence is probably no greater than among non-alcoholic individuals.

By this time, it is probably clear that the general practitioner, in order to treat successfully the alcoholics who come to him for help, must not only understand thoroughly the problem of alcoholism, but he must also have the humanitarian insight and understanding of the sometimes devious, complex and intricate motivations, impulses and reactions of the typical alcoholic.

Because the general practitioner is accustomed to deal with almost every phase of human suffering from childbirth to cancer and including their psychological aspects, he is in a uniquely advantageous position to achieve quick understanding and sympathy for the alcoholic and the complicated problems he faces in his struggle for sobriety and readjustment to a life without alcohol. Armed with the latest scientific knowledge of alcoholism and the latest methods of treatment, the general practitioner should be in the vanguard of those leading the attack on what has been aptly termed "our greatest unsolved public health problem."

Babes In The Woods

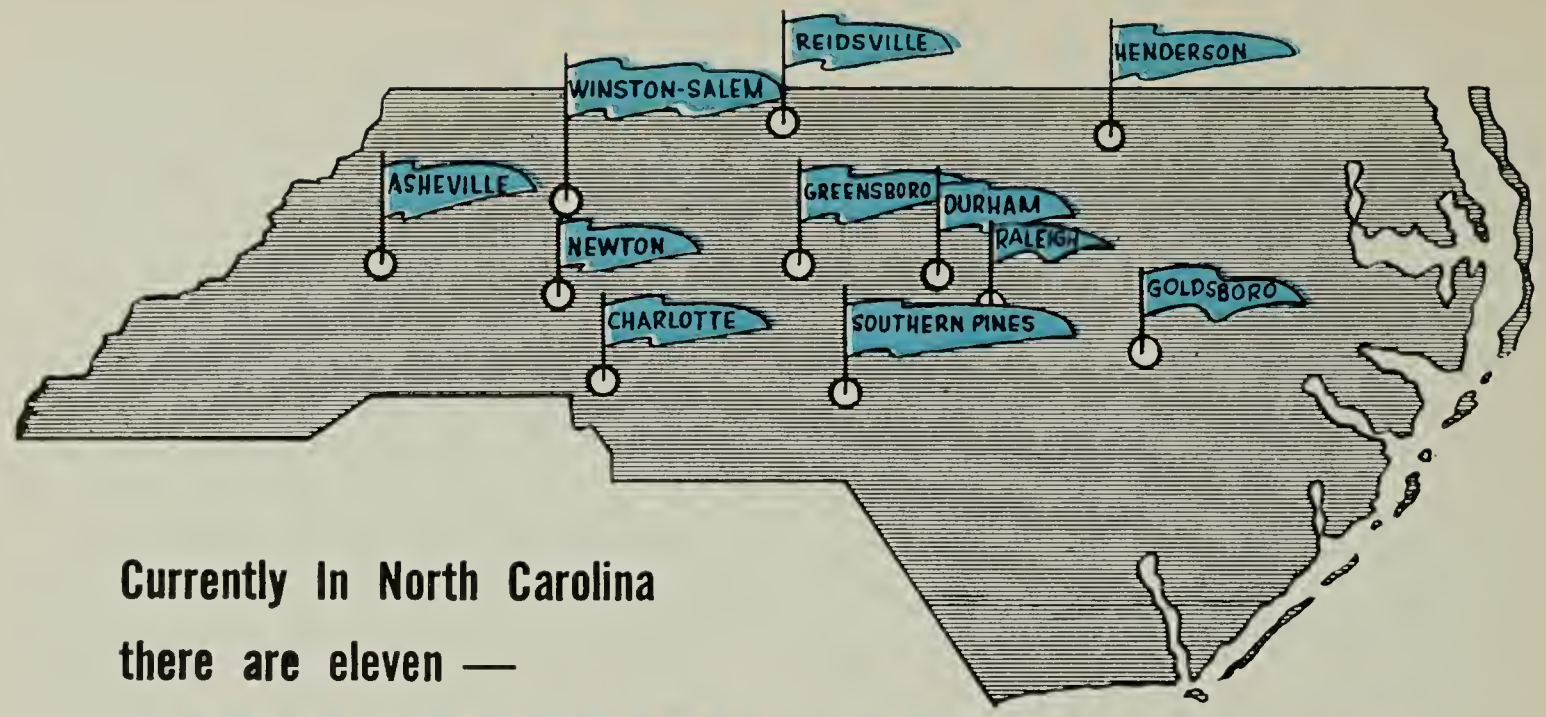
(Continued from Page 10)

patient for the symptoms of his illness.

The third question was one of sibling relationships. I spoke of the temperance groups, the liquor interests, Alcoholics Anonymous and your new State program.

If there is a single section of the talk that has any particular value, my selection would be the ten goals: informed citizens—enlighted law enforcement agencies—courts that accept alcoholic offenders as sick people—physicians and hospitals and clergymen and social agencies who use their skills to help alcoholics—public health people who accept alholism as a public health responsibility and labor and management that recognize an alcoholic employee as a sick employe, and schools that teach objectively about alcohol.

These are the goals that we aim for. They may be good for you and they may not. Congratulations to you and best wishes on your second birthday.



Currently In North Carolina there are eleven —

LOCAL PROGRAMS ON ALCOHOLISM

ASHEVILLE—
Citizens' Committee on Alcoholism
Miss Rosemary Engelbert, Chairman
(Home Address: 230 Forest Hill Drive, Asheville)
Educational Division, Board of Alcohol Control
West Wing, Parkway Office Building, Asheville
Margery J. Lord, M.D., Administrator

CHARLOTTE—
Charlotte Council on Alcoholism
1125 E. Morehead Street, Charlotte
Reverend Joseph Kellermann, Director
William Hales, Associate Director

DURHAM—
Durham Council on Alcoholism
209 Snow Building, Durham
Mrs. Olga Davis, Executive Secretary

GREENSBORO—
Educational Division, Alcoholic Board of Control
Greensboro
Mr. Worth Williams, Executive Secretary
Greensboro Council on Alcoholism
216 W. Market Street, Rm. 206, Irvin Arcade, Greensboro
Mr. Worth Williams, Executive Director

GOLDSBORO—
Goldsboro Program on Alcoholism
Goldsboro
A. T. Griffin, Jr.

HENDERSON—
Vance County Program on Alcoholism
Reverend Edward Laffman
Information Center
221 S. William St.
P. O. Box 233, Henderson

NEWTON—
Educational Division, Catawba County ABC Board
Reverend R. P. Sieving
(Home Address: 130 Pinehurst Lane, Newton)

RALEIGH—
Alcoholic Education and Rehabilitation Program
300 Raleigh Savings and Loan Assn., P. O. Box 2485, Raleigh
Robert Charlton, Educational Director

REIDSVILLE
Rockingham County Committee on Alcoholism
119 N. Scales Street, Reidsville
Mrs. Anne Wall, Executive Secretary

SOUTHERN PINES—
Moore County Alcoholic Education Committee
Rev. Martin Caldwell, Director
P. O. Box 1098, 350 S. Ridge St.
Southern Pines

WINSTON-SALEM—
Forsyth County Program on Alcoholism
Woodland and Seventh Streets, Winston-Salem

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
615 Wills Forest Rd.
RALEIGH, N. C.
Phone: TE 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: AL 3-8343
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: ED 3-5441 & ED 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: PArk 3-2471, Ext. 29
Monday through Friday

Cumberland County Guidance Center
115 Bow Street
FAYETTEVILLE, N. C.
Phone: HE 2-8120
This clinic is also serving as a temporary information center for alcoholics and their families.

Toward helping patients to re-establish satisfactory social relations, all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Displays—primarily for local public libraries; also available to school librarians and principals. All requests should be made through local public library to N. C. State Library, Raleigh.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the N. C. Alcoholic Rehabilitation Program, Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
P. O. Box 9494
Raleigh, N. C.

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